PSIC
Professional Solutions INSURANCE COMPANY

A member of NCMIC Group, Inc.
NCMIC Insurance Company
NCMIC Finance Corporation
Professional Solutions Insurance Company
NCMIC Insurance Services

14001 University Avenue, Clive, Iowa 50325-8258
Local 515-313-4500 FAX 515-313-4476

December 19, 2006

Illinois Insurance Division
Property and Casualty Compliance Unit
320 West Washington Street
Springfield, MO 62767

RE: Professional Solutions Insurance Company
FEIN: 42-1520773 NAIC Number: 11127
Physicians and Surgeons Professional Liability Rule Filing
Filing Number: PSIC MD 2006 End - Rule
Effective Date: Upon Approval

To Whom It May Concern:

Professional Solutions Insurance Company (PSIC) currently has on file with the Illinois Insurance Division a rating manual for our Physicians and Surgeons Professional Liability Program. After reviewing a previous rate filing submitted on 05/25/2006, it has come to our attention that we inadvertently revised and submitted an incorrect version of the Illinois Physicians and Surgeons Professional Liability Manual that was subsequently filed by your department on 07/01/2006.

It is our intention with this filing to resubmit amendments that were originally worked through and agreed to in our rate filing made on 06/30/2005 through SERFF (Filing #: PSIC MD 2005 Rate) that was subsequently withdrawn on 03/03/2006. Following are explanations of the amendments:

1. Addition of a 50% reduced rate applied to the undiscounted base rate for a moonlighting resident, located on page 5 of the manual.*
2. Addition of a Board Certification Credit, located on page 6 of the manual.*
3. Addition of ranges of credits and/or debits to the Scheduled Rating plan, located on pages 5 and 6 of the manual.
4. Revisions to the Experience Rating Claims Free Credits and Claims Debits factors for an individual policy, located on page 7 of the manual.*
5. The Partnership, Corporation or Professional Association with Shared Limits of Liability Endorsement (PSIC-CM-02) was replaced by the Solo Practitioner Corporation with Shared Limits of Liability Endorsement (PSIC-CM-18) that was approved/filed on 07/01/2005 through SERFF (Filing #: PSIC MD 2005). The corresponding rule is located on page 9 of the manual.*
6. Addition of the Multiple Partnerships, Corporations or Professional Associations Endorsement (PSIC-CM-19) that was approved/filed on 07/01/2005 through SERFF (Filing #: PSIC MD 2005). The corresponding rule is located on page 9 of the manual.*

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7. Addition of the Ancillary Medical Personnel Coverage Endorsement (PSIC-CM-20) that was approved/filed on 07/01/2005 through SERFF (Filing #: PSIC MD 2005). The corresponding rule is located on page 9 of the manual. The premium charge will be a factor of the highest classed MD at a mature claims made step for each ancillary provider. This rule has also been amended to only include Physician Assistants, Surgical Assistants, Nurse Practitioners, Psychologists and Nurse Anesthetists.*
8. Revisions to Section XV. - Partnership, Corporation, Professional Association Coverage, located on page 12 of the manual, that include the following:
    a. Replacing item A. with an explanation of the Sole Practitioner Corporation coverage.*
    b. Addition of item C. that explains the Multiple Corporations coverage.*
    c. Addition of item D. that explains the Ancillary Medical Personnel coverage.*

Please note that the amendments marked with an asterisk (*) above, were previously agreed to in SERFF Filing # PSIC MD 2005 Rate.

PSIC would also like to submit for your review and approval new rules associated with the two new endorsements explained below that have been submitted separately via SERFF.

1. Professional Organization as Additional Insured Endorsement (PSIC-CM-21 10/06)

    Please see page 8 of the rating manual. This endorsement would be utilized for adding a shared limit for a legal entity/corporation owned by the individual insured and/or insured members of the entity (e.g. for those that do not qualify for the sole practitioner's shared limit coverage and that do not purchase corporation separate limits). The charge would be 5% of named insured's base premium. This form may be added to more than one individual insured's policy.

2. Ancillary Medical Personnel Share Coverage Endorsement (PSIC-CM-22 10/06)

    Please see page 8 of the rating manual. This endorsement would be utilized for adding coverage for an employed, licensed mid-level ancillary provider of an insured that does not desire a separate limit, but that would otherwise be eligible for coverage with PSIC, to provide coverage for claims made against the insured individual or corporation named on the Declarations due to the action of the employee under the insured's direction and supervision, that would lead to a claim. The charge would be 5% of the highest rated insured's base premium for each licensed ancillary provider, except for Nurse Anesthetists, which will be 15%.

If you have any questions or need any additional information regarding this filing please feel free to contact me directly. I thank you in advance for your attention to this matter.

Sincerely,

Nathan Henn, CPCU
Lead Compliance Analyst
Professional Solutions Insurance Company
PH: 800-321-7015 Ext. 4525
FX: 515-313-4476
Email: nhenn@ncmic.com

Enclosures

ILLINOIS CERTIFICATION FOR MEDICAL MALPRACTICE RATES

(215 ILCS 5/155.18)(3) states that medical liability rates shall be certified in such filing by an officer of the company and a qualified actuary that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience.

I, Roger L. Schlueter, a duly authorized officer of Professional Solutions Insurance Company, am authorized to certify on behalf of the Company making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing.

I, Chad C. Karls, a duly authorized actuary of Milliman am authorized to certify on behalf of Professional Solutions Insurance Company making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing.

Chief Financial Officer — 12/19/06

Signature and Title of Authorized Insurance Company Officer — Date

Chad C. Karls, FCAS, MAAA, Consulting Actuary, Milliman — 12/15/06

Signature, Title and Designation of Authorized Actuary — Date

Insurance Company FEIN 42-1520773 Filing Number PSIC MD 2006 End - Rule

Insurer's Address 14001 University Avenue

City Clive State Iowa Zip Code 50325-8258

Contact Person's:

-Name and E-mail Nathan Henn, Lead Compliance Analyst nhenn@ncmic.com

-Direct Telephone and Fax Number 800-321-7015 ext. 4525 Fax: 515-313-4476

PSIC
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14001 University Avenue, Clive, Iowa 50325-8258
Local 515-313-4500 FAX 515-313-4476

January 18, 2007

Illinois Insurance Division
Property and Casualty Compliance Unit
Attn: Gayle Neuman
320 West Washington Street
Springfield, MO 62767

RE: Professional Solutions Insurance Company
FEIN: 42-1520773 NAIC Number: 11127
Physicians and Surgeons Professional Liability Rule Filing
Filing Number: PSIC MD 2006 End - Rule
Effective Date: Upon Approval

Dear Ms. Neuman:

Thank you for your recent emails. Please find our responses below:

- The premium installment plan is only offered to insureds whose final fully discounted premium is $500 or more. We have added language to the last paragraph in Section VII of the rating manual to clarify this.
- We never receive partial premium for payment of the extended reporting period. We require that the premium for the extended reporting period be paid in full at the time of purchase; no payment plans will be offered. We have added language to part C. of Section IX of the rating manual to clarify this.

If you have any further questions or need additional information regarding this filing please feel free to contact me directly. Thank you for your continued review of this filing.

Sincerely,

Nathan Henn, CPCU
Lead Compliance Analyst
Professional Solutions Insurance Company
PH: 800-321-7015 Ext. 4525
FX: 515-313-4476
Email: nhenn@ncmic.com

Enclosures

Neuman, Gayle

From: Nathan Henn [NHenn@ncmic.com]
Sent: Thursday, January 18, 2007 8:53 AM
To: Neuman, Gayle
Subject: RE: Rule Filing #PSIC MD 2006 End - Rule

Ms. Neuman,

Thank you for the clarification. We will make the corresponding change to our manual.

Thanks,
Nathan Henn, CPCU
Lead Compliance Analyst
NCMIC Group, Inc.
14001 University Avenue
Clive, IA 50325-8258
800-321-7015 ext. 4525
mailto:nhenn@ncmic.com

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Thursday, January 18, 2007 8:48 AM
To: Nathan Henn
Subject: RE: Rule Filing #PSIC MD 2006 End - Rule

Mr. Henn,

The law/regulation requires the quarterly installment option be offered to all insureds whose premium exceeds $500. Please correct the manual accordingly.

From: Nathan Henn [mailto:NHenn@ncmic.com]
Sent: Thursday, January 18, 2007 8:36 AM
To: Neuman, Gayle
Subject: RE: Rule Filing #PSIC MD 2006 End - Rule

Dear Ms. Neuman,

Thank you for your email yesterday. Please find our responses below:

- The premium installment plan is only offered to insureds whose final fully discounted premium is $1,000 more. We have added language to the last paragraph in Section VII of the rating manual to clarify this.
- We never receive partial premium for payment of the extended reporting period. We require that the premium for the extended reporting period be paid in full at the time of purchase; no payment plans will be offered. We have added language to part C. of Section IX of the rating manual to clarify this.

I will be overnighting revised copies of the rating manual for your review. If you have any further questions or nee additional information regarding this filing please feel free to contact me directly. Thank you for your continued review of this filing.

Nathan Henn, CPCU
Lead Compliance Analyst

NCMIC Group, Inc.
14001 University Avenue
Clive, IA 50325-8258
800-321-7015 ext. 4525
mailto:nhenn@ncmic.com

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Wednesday, January 17, 2007 9:45 AM
To: Nathan Henn
Subject: Rule Filing #PSIC MD 2006 End - Rule

Mr. Henn,

We are reviewing the above referenced rule filing submitted by your letter dated December 19, 2006.

In regard to the quarterly premium installment plan, do you only offer this to insureds whose premium exceeds $500? If so, we would request wording be added to clarify this.

In regard to the extended reporting period, the manual indicates it may be cancelled for nonpayment of premium. Most insurers only issue such tail coverage after receipt of payment. With an unlimited time period, how do you determine when to cancel the policy for non-payment of part of the premium?

We request receipt of your response by no later than January 24, 2007. Thank you for your cooperation.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Please refer to the Property and Casualty Review Requirement Checklists before submitting any filing. The checklists can be accessed through the Department's website (http://www.idfpr.com/) by clicking on: Insurance; Industry; Regulatory; IS3
Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

PROFESSIONAL SOLUTIONS INSURANCE COMPANY

STATE OF ILLINOIS

PHYSICIANS AND SURGEONS

PROFESSIONAL LIABILITY MANUAL

CLAIMS MADE COVERAGE

I. APPLICATION OF THIS MANUAL-ELIGIBILITY

This claims made program covers Physicians and Surgeons engaged in the rendering of professional services specific to their disciplines. Refer to the classification plan on page 9 for a description of each risk/rating category for physicians, surgeons.

Employees of health care professionals are also included as insureds for their acts while performing duties within the scope of their discipline while under the direction and supervision of the insured named in the coverage summary. Refer to page 11 for a listing of the ancillary employees who will be charged an additional premium for a separate limit of liability.

This program also provides coverage for both medical clinics and individual practicing physicians for the liability exposure of a partnership, corporation or professional association on either a separate or shared limit basis. Refer to the partnership, corporation or professional partnership section on page 11 for a description of the corporation rating factors.

II. PREMIUM DETERMINATION

1. Determine the base rate for the appropriate policy type and territory.
2. Refer to Classification Listing and apply the factor for the most appropriate class specialty being rated.
3. Apply the appropriate increase limit factor.
4. Apply the appropriate claims made step factor to reach the undiscounted premium.
5. Apply credit, if necessary, for new practitioner or part-time status (no further credits available, except for Size of Risk Credit).
6. Apply any credits for scheduled or experience rating.
7. Apply rounding.
8. Example Premium Calculation:

   Assume the full time undiscounted premium is $1,000 and no new practitioner or part-time status applies. Additional credits or debits will be applied in consecutive order.

   $1,000 x .95 = $950.00 (Schedule rating credit of 5%)
   $950.00 x .95 = $902.50 (Size of risk credit of 5%)
   $902.50 = $903.00 (Apply rounding)

III. POLICY PERIOD

The policy period shall be for a one-year term, unless in the middle of a claims made year. In this instance, a short-term policy may be issued to expire on the member's original expiration date. The policy period next following will be for one year.

IV. WHOLE DOLLAR PREMIUM RULE

All premiums shown on the policy and endorsements shall be rounded to the nearest whole dollar. If the premium is .50 or greater, round to next higher whole dollar. If the premium is .49 or less, round down. In the event of cancellation, the return premium shall be rounded to the nearest whole dollar. Rounding is the last step of the premium calculation.

Example: $1,234.30 is rounded to $1,234.
$1,234.60 is rounded to $1,235.

V. PRACTICE LOCATION

Practitioners who conduct a percentage of their practice located in another state or territory will be assessed additional premium, based upon the percentage of time spent in the other state or territory.

A. For insureds who practice in multiple states, the location of their primary practice will determine the base rate, with a premium debit of 25%, to be applied, based on their practice in the secondary state. The 25% debit will not be applied if the primary state's base rate is higher.

B. If more than one location of practice exists within the same state, the rate from the highest territory will be applied.

C. The insured must be licensed in all states where practicing.

VI. POLICY CANCELLATION

A. Cancellation By the Insured

The insured may cancel the policy by mailing or delivering notice to the Company stating when such cancellation shall be effective.

This policy will remain in full force and effect until its regular anniversary date unless the policy is cancelled sooner by the Company in accordance with the laws of the State of Illinois.

If the insured cancels the policy, earned premium shall be computed in accordance with the standard short rate tables and procedure. If the Company cancels the policy, earned premium shall be computed pro rata.

B. Cancellation/Non-Renewal By the Company

The Company may cancel or non-renew the policy in accordance with the insurance laws of the State of Illinois. Standard cancellation notice will be sent 60 days prior to cancellation, except that in the event of non-payment of premium, then not less than ten (10) days prior notice will be given.

VII. PREMIUM PAYMENT OPTIONS

1. Annual
2. Semi-Annual 50% prepayment required
3. Quarterly 25% prepayment required as the initial down payment with remaining payments of 25% each due at 3, 6 & 9 months after policy inception
4. Other payment options available upon request for large group accounts.

There is no installment fee charge or interest charged for utilizing the premium payment options. Additional premiums for policy changes occurring during the current policy term shall be computed pro rata of the annual premium. If there are no remaining installments, additional premium resulting from changes in coverage may be due immediately as a separate transaction.

VIII. RENEWALS

The policy will be renewed upon receipt of the required premium on or before the date of each successive policy period. The renewal premium shall be based on rates in effect on the renewal or anniversary date. The applicable forms and endorsements must be made a part of the policy. Additional premiums for policy changes occurring during the current policy term shall be computed pro rata of the annual premium.

IX. SPECIAL PROVISIONS

A. Retroactive Coverage

This extension covers incidents which occurred subsequent to the prior carrier's retroactive date, but which are neither known nor reported as of the inception date of the replacement coverage written by Professional

Solutions Insurance Company. The insured may apply for the Retroactive Date (shown on the Coverage Summary) that is equal to the retroactive date shown on the previous policy.

Premium for this extension is derived by rating the policy based upon the claims made step factor determined by using the previous carrier's retroactive date.

B. Basic Reporting Extension

This provision applies when coverage under the policy ends, either by action of the insured or the Company through cancellation, termination or non-renewal.

Under the circumstances stated above, the Company will provide a thirty (30) day Basic Reporting Extension which allows claims to be reported during this time that result from incidents that happened during the time the coverage was in force. The thirty (30) day Basic Reporting Extension does not apply if the insured purchases any subsequent insurance that replaces in whole or in part the coverage provided by this policy.

Within thirty (30) days of when the policy coverage terminates, the Company must advise the insured of the availability of Extended Reporting Coverage, the premium cost, and the importance of buying this additional coverage extension, commonly called "Tail Coverage".

The insured will have the greater of sixty (60) days from the date the coverage is terminated, or thirty (30) days from the date of notice, to accept the Extended Reporting Coverage in writing.

C. Extended Reporting Coverage, also called Tail Coverage

Extended Reporting Coverage will be provided for an unlimited time period with aggregate liability limits equal to or less than those of the expired coverage to report claims which arose from incidents that occurred when the coverage was in force. The liability limits provided by this option are the only limits that shall be applicable to the unlimited time period designated above. Extended Reporting Coverage can be applied to individual or entity policies.

The following factors will be applied to the undiscounted mature claims made premium in effect at the time the policy is terminated to calculate the extended reporting endorsement premium:

# of Years Completed in Claims Made Program	Tail Factor
1	0.92
2	1.43
3	1.70
4+	1.87

Professional Solutions Insurance Company cannot cancel the Extended Reporting Coverage except for non-payment of the additional premium.

The Company provides Extended Reporting Coverage automatically, at no additional charge, under the following circumstances:

1. The insured dies; or
2. The insured becomes permanently disables and is unable to continue their duties as a licensed insured; or
3. The insured retires. The insured must be age fifty-five (55) or older and have five (5) years of continuous coverage with Professional Solutions Insurance Company in order to qualify for free Extended Reporting Coverage.

D. Change in Rating Classification

In the event of a change in exposure or medical specialty of the practitioner, a charge reflecting the difference between the previous and such new exposure or specialty shall be calculated and collected at the time of such change unless:

1. otherwise eligible for Extended Reporting Coverage at no charge;
2. with regard to medical specialty, both the prior and the current specialty fall within the same class;

3. the exposure or medical specialty of the practitioner changed more than 4 years prior while insured under claims made coverage; or

4. the exposure or medical specialty of the practitioner changed while insured under occurrence coverage.

E. New Practitioner

A new practitioner is defined as a person who has completed his or her training within the previous six months, whose only contact with patients has been in the course of his or her training, and who has not been previously insured by Professional Solutions Insurance Company.

1st year	50% credit
2nd year	30% credit
3rd year	10% credit

Those who receive a new practitioner credit will not be eligible to receive any further credits, except for Size of Risk.

F. Part-Time Practitioner

A practitioner must practice 20 hours or less per week to become eligible for this credit. The insured must complete an application for part-time credit. If the application is approved, credits will be given by year according to the following schedule:

1st year	20% credit
2nd year	30% credit
3rd year	40% credit
4th year	50% credit

Those who receive a part-time practitioner credit will not be eligible to receive any further credits, except for Size of Risk.

G. Locum Tenens

Locum Tenens working in the place of an insured shall be provided coverage at no additional premium, for a period not to exceed forty-five (45) days per policy term. A completed application must be submitted to the company for prior underwriting approval.

H. Moonlighting Resident

Following graduation from medical school, a physician may elect to enter a residency program. Third and fourth year medical residents will be charged at the reduced rate of 50% applied to the undiscounted base rate. Those who qualify for this rating will not be eligible for any additional scheduled or experience rating.

X. SCHEDULED RATING

Professional Solutions Insurance Company will use the following schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of Professional Solutions Insurance Company uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the company.

The premium for a risk may be modified in accordance with the following, subject to a maximum modification of a 15% credit to a 40% debit to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this scheduled rating plan are subject to periodic review. The actual determination of the appropriate credit or debit will be determined through the underwriting review of the applicant's application.

1. **Cumulative Years of Patient Experience: 5% Credit**

   Insureds who have demonstrated a stable, longstanding practice and/or significant degree of experience in their area of medicine.

2. **Classification Differences: 5% Credit / 15%-25% Debit**

   Characteristics of a particular insured that differentiate the insured from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.

3. **Implementation of Loss Control Procedures: 3% or 5% Credit**

   In order to qualify for this credit, the insured must demonstrate that credible loss control procedures have been properly implemented, and that these procedures will reduce the frequency and severity of claims.

4. **Number / Type of Patient Exposure: 5%-10% Debit**

   Size and/or demographics of the patient population, which influences the frequency, and/or severity of claims.

5. **Board Certification Credit: 3% or 5% Credit**

   In order to receive this credit, the insured must provide documentation of current board certification in one or more specialties of the insured's current practice.

XI. ADDITIONAL CREDITS

Size of Risk Credit

Insureds who are part of or employees of a professional association, corporation, or other group who become insureds of Professional Solutions Insurance Company shall be eligible for a credit based on the volume of premium brought to Professional Solutions Insurance Company. Insureds may receive this credit in addition to the other individual credits available. The size of risk credit will be applied to the undiscounted, total aggregate premium of the individual insureds, plus the corporation charge.

Premium	Credit
$100,001 - $200,000	.50%
$200,001 - $300,000	1.0%
$300,001 - $400,000	1.5%
$400,001 - $500,000	2.0%
$500,001 - $600,000	2.5%
$600,001 - $700,000	3.0%
$700,001 - $800,000	3.5%
$800,001 - $900,000	4.0%
$900,001 - $1,000,000	4.5%
over $1,000,000	5.0%

XII. EXPERIENCE RATING

Claims free credits

A claim is defined as a claim closed with incurred indemnity equal to or greater than $10,000.00.

A claim free credit shall apply if the insured has achieved at least 3 years without a claim.

The following schedule will apply:

3 yrs	5%
4 yrs	6%
5 yrs	7%
6 yrs	8%
7 yrs	9%
8 yrs	10%
9yrs	11%
10 yrs	12%
11 yrs	13%
12 yrs	14%
13 yrs +	15%

Claims debits

Claim debit factors – individual policy:

Three (3) claims opened in the past five (5) years:	5%
Four (4) claims opened in the past five (5) years:	7%
Five (5) claims opened in the past five (5) years:	10%

Claim debit factors – partnership/corporate policy:

# OF CLAIMS IN 5 YEARS	FACTOR
1-2	1.000
3-4	1.500

The debit will not be based on an action that was filed or settled more than five (5) years immediately preceding the issuance or renewal of the policy.

Documentation, including copies of judgments, awards or stipulations of settlement will be requested and reviewed where available.

To obtain and verify experience applicable to each prospective insured, the Company will seek claim information from:

a. The applicant
b. The agent or broker
c. All previous insurers with respect to the experience period in question.

Solo Practitioner Corporation with Shared Limits of Liability Endorsement- Form PSIC-CM-18

This endorsement provides a shared limit of liability at no additional charge to an insured's professional entity, as long as the entity does not employ any other licensed health care providers.

Partnership, Corporation or Professional Association With Separate Limits of Liability Endorsement-Form PSIC-CM-03

This endorsement provides a separate limit of liability to a partnership, corporation or professional association. Coverage is provided only to the extent of the entity's liability for the providing of professional services within the scope and course of employment by a person included within the definition of "Persons Insured" under the policy.

Multiple Partnership, Corporation or Professional Association Endorsement- Form PSIC-CM-19

This endorsement provides a separate limit of liability that will be shared between multiple partnership(s) or corporation(s) or professional association(s). Coverage is provided only to the extent of the entities' liability for the providing of professional services within the scope and course of employment by a person included within the definition of "Persons Insured" under the policy.

Ancillary Medical Personnel Coverage Endorsement- Form PSIC-CM-20

This endorsement provides coverage for licensed ancillary medical personnel to share the separate limit of liability for the entity stated on the declaration page. Coverage is provided only for the additional liability imputed as a licensed health care provider and only while acting within the scope of licensure and as an employee of the insured entity stated on the endorsement.

Professional Organization as Additional Insured Endorsement- Form PSIC-CM-21

This endorsement will be utilized for adding a shared limit for a legal entity/corporation owned by the individual insured and/or insured members of the entity (e.g. for those that do not qualify for the sole practitioner's shared limit coverage and that do not purchase corporation separate limits). The charge for this endorsement will be 5% of the named insured's base premium. This form may be added to more than one individual insured's policy.

Ancillary Medical Personnel Shared Coverage Endorsement- Form PSIC-CM-22

This endorsement will be utilized for adding coverage for an employed, licensed mid-level ancillary provider of an insured that does not desire a separate limit, but that would otherwise be eligible for coverage with PSIC (to be used for other than the sole practitioner and for insureds that do not purchase separate entity limit coverage) to provide coverage for claims made against the insured individual or corporation named on the declaration page due to the action of the employee under the insured's direction and supervision, that would lead to a claim. The charge for this endorsement will be 5% of the highest rated insured's base premium for each licensed ancillary provider, except for Nurse Anesthetists, which will be 15%.

Additional Insured Endorsement-Form PSIC-CM-05

This endorsement provides coverage for an additional insured. This is an optional endorsement. The charge for this endorsement will be 15% of the base corporation/partnership premium.

Temporary Leave of Absence Endorsement-Form PSIC-CM-06

This endorsement may be utilized if an insured must take a leave of absence from their practice. Insureds who become disabled or take a leave of absence shall become eligible for suspension of coverage at a rate reduction of 90% of the otherwise applicable rate for the period of disability or leave of absence. The period

must extend for a minimum length of sixty (60) days or more up to a maximum of one hundred eighty (180) days or until renewal. The lower premium will apply retroactively to the first day of the disability or leave.

This option provides continued protection to the provider who experiences a temporary interruption in his or her practice (subject to the stated eligibility requirements), for claims arising from acts, errors or omissions which occurred prior to the inception of the disability or leave. There is no coverage for acts, errors or omissions during the leave or disability period. Because the policy does not cancel, there is no need for the purchase of Extended Reporting Coverage (Tail).

If disabled, proof of disability must be submitted to the Company for approval, and the calculation of the credit will be on a pro rata basis for the period of the qualifying disability.

While on disability or leave, credit toward extended reporting vesting will continue to accrue, and the insured must continue to pay premiums when due.

Eligible Situations For Temporary Leave of Absence: Short-Term Disability, Maternity Leave, Military Leave or any other reason pre-approved by Professional Solutions Insurance Company – Does not apply to vacations

Extended Reporting Endorsement-Form PSIC-CM-07

This endorsement provides coverage for an unlimited time period with aggregate liability limits equal to or less than those of the expired coverage to report claims, which arose from incidents that occurred when the coverage was in force. The liability limits provided by this option are the only limits that shall be applicable to the unlimited time period designated above. This endorsement can be applied to group or entity policies.

Medical Laboratory Endorsement-Form PSIC-CM-10

This endorsement provides a shared limit of liability to a medical laboratory facility. The premium for the endorsement is based on the following:

a. at no additional charge if such laboratory is not a separate entity. Coverage is limited to the testing of the insured's own patients.

b. as an additional insured at 25% of the mature Class 1 rate, if such laboratory is a separate entity. Coverage is limited to the testing of the insured's own patients.

Specialty Classification Amendment Endorsement-Form PSIC-CM-11

This endorsement will be attached to the policy if the insured amends their medical specialty during the policy period. This endorsement will extend coverage for claims that are reported under the insured's previous medical specialty. The premium will be adjusted based on the change of the specialty classification.

XIV. Classification Plan – Refer to rate sheet for base rate information.

ISO Specialty Codes M.D.	D.O.	Class	Description	FACTOR
80230		1	Aerospace Medicine	0.650
80254		1	Allergy/Immunology	0.650
80256		1	Dermatology - No Surgery	0.650
80240		1	Forensic Medicine	0.650
80248		1	Nutrition	0.650
80233		1	Occupational Medicine	0.650
80263		1	Ophthalmology - No Surgery	0.650
80235		1	Physiatry/Physical Medicine	0.650
80231		1	Preventive Medicine - No Surgery	0.650
80251		1	Psychosomatic Medicine	0.650

80236	1	Public Health	0.650
80237	2	Diabetes No Surgery	0.850
80238	2	Endocrinology - No Surgery	0.850
80243	2	Geriatrics - No Surgery	0.850
80244	2	Gynecology - No Surgery	0.850
80260	2	Nephrology - No Surgery	0.850
80262	2	Nuclear Medicine	0.850
80268	2	Physicians - No Surgery N.O.C.	0.850
80995	2	Podiatry - Soft Tissue	0.850
80249	2	Psychiatry including child	0.850
80252	2	Rheumatology - No Surgery	0.850
80255	3	Cardiovascular Disease - No Surgery	1.000
80420	**3**	**Family Phys. Or Gen. Prac. - No Surgery**	**1.000**
80241	3	Gastroenterology - No Surgery	1.000
80245	3	Hematology - No Surgery	1.000
80246	3	Infectious Diseases - No Surgery	1.000
80258	3	Laryngology - No Surgery	1.000
80259	3	Neoplastic Diseases - No Surgery	1.000
80302	3	Oncology No Surgery	1.000
80264	3	Otology - No Surgery	1.000
80265	3	Otorhinolaryngology - No Surgery	1.000
80266	3	Pathology No Surgery	1.000
80269	3	Pulmonary Diseases - No Surgery	1.000
80247	3	Rhinology - No Surgery	1.000
80257	4	Internal Medicine - No Surgery	1.250
80287	4	Nephrology - Minor Surgery	1.250
80301	4	Oncology - Minor Surgery	1.250
80289	4	Ophthalmology - Minor Surgery	1.250
80114	4	Opthalmology - Surgery	1.250
80267	4	Pediatrics - No Surgery	1.250
80298	4	Pulmonary Diseases - Minor Surgery	1.250
80281	5	Cardiovascular Disease - Minor Surgery	1.500
80282	5	Dermatology - Minor Surgery	1.500
80271	5	Diabetes - Minor Surgery	1.500
80272	5	Endocrinology - Minor Surgery	1.500
80274	5	Gastroenterology - Minor Surgery	1.500
80276	5	Geriatrics - Minor Surgery	1.500
80277	5	Gynecology - Minor Surgery	1.500
80278	5	Hematology - Minor Surgery	1.500
80279	5	Infectious Diseases - Minor Surgery	1.500
80284	5	Internal Medicine - Minor Surgery	1.500
80285	5	Laryngology - Minor Surgery	1.500
80261	5	Neurology - No Surgery	1.500
80290	5	Otology - Minor Surgery	1.500
80291	5	Otorhinolaryngology - Minor Surgery	1.500
80294	5	Physicians - Minor Surgery N.O.C.	1.500
80253	5	Radiology Diagnostic - No Surgery	1.500
80270	5	Rhinology - Minor Surgery	1.500
80145	5	Urological Surgery	1.500
80151	6	Anesthesiology	1.650
80421	6	Family Phys. Or Gen. Prac.- Minor Surgery	1.650
80283	6	Intensive Care Medicine	1.650
80286	6	Neoplastic Diseases - Minor Surgery	1.650

80288	5	Neurology - Minor Surgery	1.650
80292	6	Pathology - Minor Surgery	1.650
80293	6	Pediatrics - Minor Surgery	1.650
80101	7	Broncho-Esophagology	2.150
80103	7	Endocrinology Surgery	2.150
80104	7	Gastroenterology Surgery	2.150
80105	7	Geriatrics Surgery	2.150
80804	7	Neonatal/Perinatal Medicine	2.150
80108	7	Nephrology Surgery	2.150
80159	7	Otorhinolaryngology - No Plastic Surgery	2.150
80280	7	Radiology Diagnostic - Minor Surgery	2.150
80115	8	Colon and Rectal Surgery	2.500
80106	8	Laryngology Surgery	2.500
80107	8	Neoplastic Surgery	2.500
80164	8	Oncology Surgery	2.500
80158	8	Otology	2.500
80136	8	Radiology Including Radiation Therapy	2.500
80160	8	Rhinology Surgery	2.500
80102	9	Emergency Medicine - No Major Surgery	3.000
80117	9	General Prac. or Family Prac. Surgery	3.000
80143	9	General Surgery	3.000
80169	10	Hand Surgery	3.350
89154	10	Orthopedic Surgery - No Spine	3.350
80155	10	Otorhinolaryngology w/Plastic Surgery	3.350
80166	11	Abdominal Surgery	3.750
80157	11	Emergency Medicine Surgery	3.750
80167	11	Gynecology Surgery	3.750
80170	11	Head and Neck Surgery	3.750
80141	12	Cardiac Surgery	4.500
80150	12	Cardiovascular Disease Surgery	4.500
80154	12	Orthopedic Surgery - Including Spine	4.500
80156	12	Plastic N.O.C. Surgery	4.500
80144	12	Thoracic Surgery	4.500
80171	12	Traumatic Surgery	4.500
80146	12	Vascular Surgery	4.500
80153	13	Obstetrics Gynecology Surgery	5.500
80168	13	Obstetrics Surgery	5.500
80152	14	Neurology Surgery	6.750

Ancillary Provider Rating:

Ancillary Provider	**Separate Limits Factor**
Physician Assistant	0.200
Surgical Assistant	0.200
Nurse Practitioner	0.200
Psychologist	0.250
Nurse Anesthetist	0.560

XV. Partnership-Corporation-Professional Association Coverage

A. Sole Practitioner Corporation:

Coverage for an insured's professional entity may be written with a shared limit of liability at no additional charge as long as the entity does not employ any other licensed health care providers.

B. Separate Limits of Liability:

Coverage for partnerships, corporations, or professional associations may be written with a separate limit of liability. The premium charge for separate limits will be a percentage of the total undiscounted liability premium for all practitioners. The percentage will vary based on the number of insureds in the corporation.

Number of Insureds	Percent
2-5	15.0%
6-9	12.0%
10-19	9.0%
20-49	7.0%
50 or more	5.0%

C. Multiple Corporations:

Coverage for multiple partnership(s), corporation(s) or professional association(s) may be written with a separate limit of liability shared among the multiple entities. The premium charge for separate limits will be a percentage of the total undiscounted liability premium for all practitioners in the primary entity. The percentage will vary based on the number of insureds in the primary entity. There is no additional charge for each additional entity that will share in this separate limit.

Number of Insureds	Percent
2-5	15.0%
6-9	12.0%
10-19	9.0%
20-49	7.0%
50 or more	5.0%

D. Ancillary Medical Personnel Coverage:

Coverage for licensed ancillary medical personnel may be written so the ancillary medical personnel share the separate limit of liability with the entity stated on the declaration page. The premium charge for sharing the entity's separate limits will be a factor of the highest classed insured at a mature claims made step for each ancillary provider that will be named on the endorsement.

Licensed Ancillary Provider	Shared Limits Factor
Physician Assistant	0.050
Surgical Assistant	0.050
Nurse Practitioner	0.050
Psychologist	0.050
Nurse Anesthetist	0.150

XVI. Rates

Physicians and Surgeons Mature Claims Made Rate (for Class 3 provider @ 100/300 limits)

Illinois Territory 01 - **(Cook, Madison and St. Clair counties)**	**$12,110.00**
Illinois Territory 02 - **(DePage, Kane, Lake, McHenry and Will counties)**	**$8,967.00**
Illinois Territory 03 - **(Champaign, Macon, Jackson, Vermillion, Sangamon, DeKalb, Kankakee, LaSalle, Ogle, Randolph, Winnebego and Jackson counties)**	**$7,911.00**
Illinois Territory 04 - **(Remainder of State)**	**$5,800.00**

Increase limit factors: The applicable limit factor is determined by the chosen limit option on the application.

Limits of Liability	Increase Limit Factors
$100,000/$300,000	1.000
$200,000/$600,000	1.375
$250,000/$750,000	1.500
$500,000/$1,000,000	1.875
$1,000,000/$3,000,000	2.500
$2,000,000/$4,000,000	3.125

Claims-Made Step Factors:

Year	Claims-Made Step Factor
1	0.35
2	0.66
3	0.90
4	0.98
Mature	1.00

6th Month Rule: If the period between the retroactive date and the policy effective date is less than 6 months, rate at year 1. If the period is more than 6 months, rate at year 2, with each of the next consecutive claims made step increases applied at each renewal.

Side-by-Side Rating Manual Comparison

Attached please find a comparison of Professional Solutions Insurance Company's currently approved rating manual and Professional Solutions Insurance Company's revised rating manual. All information that has been deleted from the currently approved manual is in [brackets] and all new information that has been added to the new proposed manual is underlined.

PROFESSIONAL SOLUTIONS INSURANCE COMPANY

STATE OF ILLINOIS

PHYSICIANS AND SURGEONS

PROFESSIONAL LIABILITY MANUAL

CLAIMS MADE COVERAGE

I. APPLICATION OF THIS MANUAL-ELIGIBILITY

This claims made program covers Physicians and Surgeons engaged in the rendering of professional services specific to their disciplines. Refer to the classification plan on page 9 for a description of each risk/rating category for physicians, surgeons.

Employees of health care professionals are also included as insureds for their acts while performing duties within the scope of their discipline while under the direction and supervision of the insured named in the coverage summary. Refer to page 11 for a listing of the ancillary employees who will be charged an additional premium for a separate limit of liability.

This program also provides coverage for both medical clinics and individual practicing physicians for the liability exposure of a partnership, corporation or professional association on either a separate or shared limit basis. Refer to the partnership, corporation or professional partnership section on page 11 for a description of the corporation rating factors.

II. PREMIUM DETERMINATION

1. Determine the base rate for the appropriate policy type and territory.
2. Refer to Classification Listing and apply the factor for the most appropriate class specialty being rated.
3. Apply the appropriate increase limit factor.
4. Apply the appropriate claims made step factor to reach the undiscounted premium.
5. Apply credit, if necessary, for new practitioner or part-time status (no further credits available, except for Size of Risk Credit).
6. Apply any credits for scheduled or experience rating.
7. Apply rounding.
8. Example Premium Calculation:

   Assume the full time undiscounted premium is $1,000 and no new practitioner or part-time status applies. Additional credits or debits will be applied in consecutive order.

   $1,000 x .95 = $950.00 (Schedule rating credit of 5%)
   $950.00 x .95 = $902.50 (Size of risk credit of 5%)
   $902.50 = $903.00 (Apply rounding)

III. POLICY PERIOD

The policy period shall be for a one-year term, unless in the middle of a claims made year. In this instance, a short-term policy may be issued to expire on the member's original expiration date. The policy period next following will be for one year.

IV. WHOLE DOLLAR PREMIUM RULE

All premiums shown on the policy and endorsements shall be rounded to the nearest whole dollar. If the premium is .50 or greater, round to next higher whole dollar. If the premium is .49 or less, round down. In the event of cancellation, the return premium shall be rounded to the nearest whole dollar. Rounding is the last step of the premium calculation.

Example: $1,234.30 is rounded to $1,234.
$1,234.60 is rounded to $1,235.

V. PRACTICE LOCATION

Practitioners who conduct a percentage of their practice located in another state or territory will be assessed additional premium, based upon the percentage of time spent in the other state or territory.

A. For insureds who practice in multiple states, the location of their primary practice will determine the base rate, with a premium debit of 25%, to be applied, based on their practice in the secondary state. The 25% debit will not be applied if the primary state's base rate is higher.

B. If more than one location of practice exists within the same state, the rate from the highest territory will be applied.

C. The insured must be licensed in all states where practicing.

VI. POLICY CANCELLATION

A. Cancellation By the Insured

The insured may cancel the policy by mailing or delivering notice to the Company stating when such cancellation shall be effective.

This policy will remain in full force and effect until its regular anniversary date unless the policy is cancelled sooner by the Company in accordance with the laws of the State of Illinois.

If the insured cancels the policy, earned premium shall be computed in accordance with the standard short rate tables and procedure. If the Company cancels the policy, earned premium shall be computed pro rata.

B. Cancellation/Non-Renewal By the Company

The Company may cancel or non-renew the policy in accordance with the insurance laws of the State of Illinois. Standard cancellation notice will be sent 60 days prior to cancellation, except that in the event of non-payment of premium, then not less than ten (10) days prior notice will be given.

VII. PREMIUM PAYMENT OPTIONS

1. Annual
2. Semi-Annual — 50% prepayment required
3. Quarterly — 25% prepayment required as the initial down payment with remaining payments of 25% each due at 3, 6 & 9 months after policy inception
4. Other payment options available upon request for large group accounts.

There is no installment fee charge or interest charged for utilizing the premium payment options. Additional premiums for policy changes occurring during the current policy term shall be computed pro rata of the annual premium. If there are no remaining installments, additional premium resulting from changes in coverage may be due immediately as a separate transaction.

VIII. RENEWALS

The policy will be renewed upon receipt of the required premium on or before the date of each successive policy period. The renewal premium shall be based on rates in effect on the renewal or anniversary date. The applicable forms and endorsements must be made a part of the policy. Additional premiums for policy changes occurring during the current policy term shall be computed pro rata of the annual premium.

IX. SPECIAL PROVISIONS

A. Retroactive Coverage

This extension covers incidents which occurred subsequent to the prior carrier's retroactive date, but which are neither known nor reported as of the inception date of the replacement coverage written by Professional

Solutions Insurance Company. The insured may apply for the Retroactive Date (shown on the Coverage Summary) that is equal to the retroactive date shown on the previous policy.

Premium for this extension is derived by rating the policy based upon the claims made step factor determined by using the previous carrier's retroactive date.

B. Basic Reporting Extension

This provision applies when coverage under the policy ends, either by action of the insured or the Company through cancellation, termination or non-renewal.

Under the circumstances stated above, the Company will provide a thirty (30) day Basic Reporting Extension which allows claims to be reported during this time that result from incidents that happened during the time the coverage was in force. The thirty (30) day Basic Reporting Extension does not apply if the insured purchases any subsequent insurance that replaces in whole or in part the coverage provided by this policy.

Within thirty (30) days of when the policy coverage terminates, the Company must advise the insured of the availability of Extended Reporting Coverage, the premium cost, and the importance of buying this additional coverage extension, commonly called "Tail Coverage".

The insured will have the greater of sixty (60) days from the date the coverage is terminated, or thirty (30) days from the date of notice, to accept the Extended Reporting Coverage in writing.

C. Extended Reporting Coverage, also called Tail Coverage

Extended Reporting Coverage will be provided for an unlimited time period with aggregate liability limits equal to or less than those of the expired coverage to report claims which arose from incidents that occurred when the coverage was in force. The liability limits provided by this option are the only limits that shall be applicable to the unlimited time period designated above. Extended Reporting Coverage can be applied to individual or entity policies.

The following factors will be applied to the undiscounted mature claims made premium in effect at the time the policy is terminated to calculate the extended reporting endorsement premium:

# of Years Completed in Claims Made Program	Tail Factor
1	0.92
2	1.43
3	1.70
4+	1.87

Professional Solutions Insurance Company cannot cancel the Extended Reporting Coverage except for non-payment of the additional premium.

The Company provides Extended Reporting Coverage automatically, at no additional charge, under the following circumstances:

1. The insured dies; or
2. The insured becomes permanently disables and is unable to continue their duties as a licensed insured; or
3. The insured retires. The insured must be age fifty-five (55) or older and have five (5) years of continuous coverage with Professional Solutions Insurance Company in order to qualify for free Extended Reporting Coverage.

D. Change in Rating Classification

In the event of a change in exposure or medical specialty of the practitioner, a charge reflecting the difference between the previous and such new exposure or specialty shall be calculated and collected at the time of such change unless:

1. otherwise eligible for Extended Reporting Coverage at no charge;
2. with regard to medical specialty, both the prior and the current specialty fall within the same class;

3. the exposure or medical specialty of the practitioner changed more than 4 years prior while insured under claims made coverage; or

4. the exposure or medical specialty of the practitioner changed while insured under occurrence coverage.

E. New Practitioner

A new practitioner is defined as a person who has completed his or her training within the previous six months, whose only contact with patients has been in the course of his or her training, and who has not been previously insured by Professional Solutions Insurance Company.

1st year	50% credit
2nd year	30% credit
3rd year	10% credit

Those who receive a new practitioner credit will not be eligible to receive any further credits, except for Size of Risk.

F. Part-Time Practitioner

A practitioner must practice 20 hours or less per week to become eligible for this credit. The insured must complete an application for part-time credit. If the application is approved, credits will be given by year according to the following schedule:

1st year	20% credit
2nd year	30% credit
3rd year	40% credit
4th year	50% credit

Those who receive a part-time practitioner credit will not be eligible to receive any further credits, except for Size of Risk.

G. Locum Tenens

Locum Tenens working in the place of an insured shall be provided coverage at no additional premium, for a period not to exceed forty-five (45) days per policy term. A completed application must be submitted to the company for prior underwriting approval.

H. Moonlighting Resident

Following graduation from medical school, a physician may elect to enter a residency program. Third and fourth year medical residents will be charged at the reduced rate of 50% applied to the undiscounted base rate. Those who qualify for this rating will not be eligible for any additional scheduled or experience rating.

X. SCHEDULED RATING

Professional Solutions Insurance Company will use the following schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of Professional Solutions Insurance Company uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the company.

The premium for a risk may be modified in accordance with the following, subject to a maximum modification of a 15% credit to a 40% debit to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this scheduled rating plan are subject to periodic review. The actual determination of the appropriate credit or debit will be determined through the underwriting review of the applicant's application.

1. **Cumulative Years of Patient Experience: 5% Credit**

   Insureds who have demonstrated a stable, longstanding practice and/or significant degree of experience in their area of medicine.

2. **Classification Differences: 5% Credit / 15%-25% Debit**

   Characteristics of a particular insured that differentiate the insured from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.

3. **Implementation of Loss Control Procedures: 3% or 5% Credit**

   In order to qualify for this credit, the insured must demonstrate that credible loss control procedures have been properly implemented, and that these procedures will reduce the frequency and severity of claims.

4. **Number / Type of Patient Exposure: 5%-10% Debit**

   Size and/or demographics of the patient population, which influences the frequency, and/or severity of claims.

5. **Board Certification Credit: 3% or 5% Credit**

   In order to receive this credit, the insured must provide documentation of current board certification in one or more specialties of the insured's current practice.

XI. ADDITIONAL CREDITS

Size of Risk Credit

Insureds who are part of or employees of a professional association, corporation, or other group who become insureds of Professional Solutions Insurance Company shall be eligible for a credit based on the volume of premium brought to Professional Solutions Insurance Company. Insureds may receive this credit in addition to the other individual credits available. The size of risk credit will be applied to the undiscounted, total aggregate premium of the individual insureds, plus the corporation charge.

Premium	Credit
$100,001 - $200,000	.50%
$200,001 - $300,000	1.0%
$300,001 - $400,000	1.5%
$400,001 - $500,000	2.0%
$500,001 - $600,000	2.5%
$600,001 - $700,000	3.0%
$700,001 - $800,000	3.5%
$800,001 - $900,000	4.0%
$900,001 - $1,000,000	4.5%
over $1,000,000	5.0%

XII. EXPERIENCE RATING

Claims free credits

A claim is defined as a claim closed with incurred indemnity equal to or greater than $10,000.00.

A claim free credit shall apply if the insured has achieved at least 3 years without a claim.

The following schedule will apply:

3 yrs	5%
4 yrs	6%
5 yrs	7%
6 yrs	8%
7 yrs	9%
8 yrs	10%
9yrs	11%
10 yrs	12%
11 yrs	13%
12 yrs	14%
13 yrs +	15%

Claims debits

Claim debit factors – individual policy:

Three (3) claims opened in the past five (5) years:	5%
Four (4) claims opened in the past five (5) years:	7%
Five (5) claims opened in the past five (5) years:	10%

Claim debit factors – partnership/corporate policy:

# OF CLAIMS IN 5 YEARS	FACTOR
1-2	1.000
3-4	1.500

The debit will not be based on an action that was filed or settled more than five (5) years immediately preceding the issuance or renewal of the policy.

Documentation, including copies of judgments, awards or stipulations of settlement will be requested and reviewed where available.

To obtain and verify experience applicable to each prospective insured, the Company will seek claim information from:

a. The applicant
b. The agent or broker
c. All previous insurers with respect to the experience period in question.

Solo Practitioner Corporation with Shared Limits of Liability Endorsement- Form PSIC-CM-18

This endorsement provides a shared limit of liability at no additional charge to an insured's professional entity, as long as the entity does not employ any other licensed health care providers.

Partnership, Corporation or Professional Association With Separate Limits of Liability Endorsement-Form PSIC-CM-03

This endorsement provides a separate limit of liability to a partnership, corporation or professional association. Coverage is provided only to the extent of the entity's liability for the providing of professional services within the scope and course of employment by a person included within the definition of "Persons Insured" under the policy.

Multiple Partnership, Corporation or Professional Association Endorsement- Form PSIC-CM-19

This endorsement provides a separate limit of liability that will be shared between multiple partnership(s) or corporation(s) or professional association(s). Coverage is provided only to the extent of the entities' liability for the providing of professional services within the scope and course of employment by a person included within the definition of "Persons Insured" under the policy.

Ancillary Medical Personnel Coverage Endorsement- Form PSIC-CM-20

This endorsement provides coverage for licensed ancillary medical personnel to share the separate limit of liability for the entity stated on the declaration page. Coverage is provided only for the additional liability imputed as a licensed health care provider and only while acting within the scope of licensure and as an employee of the insured entity stated on the endorsement.

Professional Organization as Additional Insured Endorsement- Form PSIC-CM-21

This endorsement will be utilized for adding a shared limit for a legal entity/corporation owned by the individual insured and/or insured members of the entity (e.g. for those that do not qualify for the sole practitioner's shared limit coverage and that do not purchase corporation separate limits). The charge for this endorsement will be 5% of the named insured's base premium. This form may be added to more than one individual insured's policy.

Ancillary Medical Personnel Shared Coverage Endorsement- Form PSIC-CM-22

This endorsement will be utilized for adding coverage for an employed, licensed mid-level ancillary provider of an insured that does not desire a separate limit, but that would otherwise be eligible for coverage with PSIC (to be used for other than the sole practitioner and for insureds that do not purchase separate entity limit coverage) to provide coverage for claims made against the insured individual or corporation named on the declaration page due to the action of the employee under the insured's direction and supervision, that would lead to a claim. The charge for this endorsement will be 5% of the highest rated insured's base premium for each licensed ancillary provider, except for Nurse Anesthetists, which will be 15%.

Additional Insured Endorsement-Form PSIC-CM-05

This endorsement provides coverage for an additional insured. This is an optional endorsement. The charge for this endorsement will be 15% of the base corporation/partnership premium.

Temporary Leave of Absence Endorsement-Form PSIC-CM-06

This endorsement may be utilized if an insured must take a leave of absence from their practice. Insureds who become disabled or take a leave of absence shall become eligible for suspension of coverage at a rate reduction of 90% of the otherwise applicable rate for the period of disability or leave of absence. The period

must extend for a minimum length of sixty (60) days or more up to a maximum of one hundred eighty (180) days or until renewal. The lower premium will apply retroactively to the first day of the disability or leave.

This option provides continued protection to the provider who experiences a temporary interruption in his or her practice (subject to the stated eligibility requirements), for claims arising from acts, errors or omissions which occurred prior to the inception of the disability or leave. There is no coverage for acts, errors or omissions during the leave or disability period. Because the policy does not cancel, there is no need for the purchase of Extended Reporting Coverage (Tail).

If disabled, proof of disability must be submitted to the Company for approval, and the calculation of the credit will be on a pro rata basis for the period of the qualifying disability.

While on disability or leave, credit toward extended reporting vesting will continue to accrue, and the insured must continue to pay premiums when due.

Eligible Situations For Temporary Leave of Absence: Short-Term Disability, Maternity Leave, Military Leave or any other reason pre-approved by Professional Solutions Insurance Company – Does not apply to vacations

Extended Reporting Endorsement-Form PSIC-CM-07

This endorsement provides coverage for an unlimited time period with aggregate liability limits equal to or less than those of the expired coverage to report claims, which arose from incidents that occurred when the coverage was in force. The liability limits provided by this option are the only limits that shall be applicable to the unlimited time period designated above. This endorsement can be applied to group or entity policies.

Medical Laboratory Endorsement-Form PSIC-CM-10

This endorsement provides a shared limit of liability to a medical laboratory facility. The premium for the endorsement is based on the following:

a. at no additional charge if such laboratory is not a separate entity. Coverage is limited to the testing of the insured's own patients.

b. as an additional insured at 25% of the mature Class 1 rate, if such laboratory is a separate entity. Coverage is limited to the testing of the insured's own patients.

Specialty Classification Amendment Endorsement-Form PSIC-CM-11

This endorsement will be attached to the policy if the insured amends their medical specialty during the policy period. This endorsement will extend coverage for claims that are reported under the insured's previous medical specialty. The premium will be adjusted based on the change of the specialty classification.

XIV. Classification Plan – Refer to rate sheet for base rate information.

ISO Specialty Codes M.D.	ISO Specialty Codes D.O.	Class	Description	FACTOR
80230		1	Aerospace Medicine	0.650
80254		1	Allergy/Immunology	0.650
80256		1	Dermatology - No Surgery	0.650
80240		1	Forensic Medicine	0.650
80248		1	Nutrition	0.650
80233		1	Occupational Medicine	0.650
80263		1	Ophthalmology - No Surgery	0.650
80235		1	Physiatry/Physical Medicine	0.650
80231		1	Preventive Medicine - No Surgery	0.650
80251		1	Psychosomatic Medicine	0.650

80236	1	Public Health	0.650
80237	2	Diabetes No Surgery	0.850
80238	2	Endocrinology - No Surgery	0.850
80243	2	Geriatrics - No Surgery	0.850
80244	2	Gynecology - No Surgery	0.850
80260	2	Nephrology - No Surgery	0.850
80262	2	Nuclear Medicine	0.850
80268	2	Physicians - No Surgery N.O.C.	0.850
80995	2	Podiatry - Soft Tissue	0.850
80249	2	Psychiatry including child	0.850
80252	2	Rheumatology - No Surgery	0.850
80255	3	Cardiovascular Disease - No Surgery	1.000
80420	**3**	**Family Phys. Or Gen. Prac. - No Surgery**	**1.000**
80241	3	Gastroenterology - No Surgery	1.000
80245	3	Hematology - No Surgery	1.000
80246	3	Infectious Diseases - No Surgery	1.000
80258	3	Laryngology - No Surgery	1.000
80259	3	Neoplastic Diseases - No Surgery	1.000
80302	3	Oncology No Surgery	1.000
80264	3	Otology - No Surgery	1.000
80265	3	Otorhinolaryngology - No Surgery	1.000
80266	3	Pathology No Surgery	1.000
80269	3	Pulmonary Diseases - No Surgery	1.000
80247	3	Rhinology - No Surgery	1.000
80257	4	Internal Medicine - No Surgery	1.250
80287	4	Nephrology - Minor Surgery	1.250
80301	4	Oncology - Minor Surgery	1.250
80289	4	Ophthalmology - Minor Surgery	1.250
80114	4	Opthalmology - Surgery	1.250
80267	4	Pediatrics - No Surgery	1.250
80298	4	Pulmonary Diseases - Minor Surgery	1.250
80281	5	Cardiovascular Disease - Minor Surgery	1.500
80282	5	Dermatology - Minor Surgery	1.500
80271	5	Diabetes - Minor Surgery	1.500
80272	5	Endocrinology - Minor Surgery	1.500
80274	5	Gastroenterology - Minor Surgery	1.500
80276	5	Geriatrics - Minor Surgery	1.500
80277	5	Gynecology - Minor Surgery	1.500
80278	5	Hematology - Minor Surgery	1.500
80279	5	Infectious Diseases - Minor Surgery	1.500
80284	5	Internal Medicine - Minor Surgery	1.500
80285	5	Laryngology - Minor Surgery	1.500
80261	5	Neurology - No Surgery	1.500
80290	5	Otology - Minor Surgery	1.500
80291	5	Otorhinolaryngology - Minor Surgery	1.500
80294	5	Physicians - Minor Surgery N.O.C.	1.500
80253	5	Radiology Diagnostic - No Surgery	1.500
80270	5	Rhinology - Minor Surgery	1.500
80145	5	Urological Surgery	1.500
80151	6	Anesthesiology	1.650
80421	6	Family Phys. Or Gen. Prac.- Minor Surgery	1.650
80283	6	Intensive Care Medicine	1.650
80286	6	Neoplastic Diseases - Minor Surgery	1.650

80288	6	Neurology - Minor Surgery	1.650
80292	6	Pathology - Minor Surgery	1.650
80293	6	Pediatrics - Minor Surgery	1.650
80101	7	Broncho-Esophagology	2.150
80103	7	Endocrinology Surgery	2.150
80104	7	Gastroenterology Surgery	2.150
80105	7	Geriatrics Surgery	2.150
80804	7	Neonatal/Perinatal Medicine	2.150
80108	7	Nephrology Surgery	2.150
80159	7	Otorhinolaryngology - No Plastic Surgery	2.150
80280	7	Radiology Diagnostic - Minor Surgery	2.150
80115	8	Colon and Rectal Surgery	2.500
80106	8	Laryngology Surgery	2.500
80107	8	Neoplastic Surgery	2.500
80164	8	Oncology Surgery	2.500
80158	8	Otology	2.500
80136	8	Radiology Including Radiation Therapy	2.500
80160	8	Rhinology Surgery	2.500
80102	9	Emergency Medicine - No Major Surgery	3.000
80117	9	General Prac. or Family Prac. Surgery	3.000
80143	9	General Surgery	3.000
80169	10	Hand Surgery	3.350
89154	10	Orthopedic Surgery - No Spine	3.350
80155	10	Otorhinolaryngology w/Plastic Surgery	3.350
80166	11	Abdominal Surgery	3.750
80157	11	Emergency Medicine Surgery	3.750
80167	11	Gynecology Surgery	3.750
80170	11	Head and Neck Surgery	3.750
80141	12	Cardiac Surgery	4.500
80150	12	Cardiovascular Disease Surgery	4.500
80154	12	Orthopedic Surgery - Including Spine	4.500
80156	12	Plastic N.O.C. Surgery	4.500
80144	12	Thoracic Surgery	4.500
80171	12	Traumatic Surgery	4.500
80146	12	Vascular Surgery	4.500
80153	13	Obstetrics Gynecology Surgery	5.500
80168	13	Obstetrics Surgery	5.500
80152	14	Neurology Surgery	6.750

Ancillary Provider Rating:

Ancillary Provider	**Separate Limits Factor**
Physician Assistant	0.200
Surgical Assistant	0.200
Nurse Practitioner	0.200
Psychologist	0.250
Nurse Anesthetist	0.560

XV. Partnership-Corporation-Professional Association Coverage

A. Sole Practitioner Corporation:

Coverage for an insured's professional entity may be written with a shared limit of liability at no additional charge as long as the entity does not employ any other licensed health care providers.

B. Separate Limits of Liability:

Coverage for partnerships, corporations, or professional associations may be written with a separate limit of liability. The premium charge for separate limits will be a percentage of the total undiscounted liability premium for all practitioners. The percentage will vary based on the number of insureds in the corporation.

Number of Insureds	Percent
2-5	15.0%
6-9	12.0%
10-19	9.0%
20-49	7.0%
50 or more	5.0%

C. Multiple Corporations:

Coverage for multiple partnership(s), corporation(s) or professional association(s) may be written with a separate limit of liability shared among the multiple entities. The premium charge for separate limits will be a percentage of the total undiscounted liability premium for all practitioners in the primary entity. The percentage will vary based on the number of insureds in the primary entity. There is no additional charge for each additional entity that will share in this separate limit.

Number of Insureds	Percent
2-5	15.0%
6-9	12.0%
10-19	9.0%
20-49	7.0%
50 or more	5.0%

D. Ancillary Medical Personnel Coverage:

Coverage for licensed ancillary medical personnel may be written so the ancillary medical personnel share the separate limit of liability with the entity stated on the declaration page. The premium charge for sharing the entity's separate limits will be a factor of the highest classed insured at a mature claims made step for each ancillary provider that will be named on the endorsement.

Licensed Ancillary Provider	Shared Limits Factor
Physician Assistant	0.050
Surgical Assistant	0.050
Nurse Practitioner	0.050
Psychologist	0.050
Nurse Anesthetist	0.150

XVI. Rates

Physicians and Surgeons Mature Claims Made Rate (for Class 3 provider @ 100/300 limits)

Illinois Territory 01 - **(Cook, Madison and St. Clair counties)**	**$12,110.00**
Illinois Territory 02 - **(DePage, Kane, Lake, McHenry and Will counties)**	**$8,967.00**
Illinois Territory 03 - **(Champaign, Macon, Jackson, Vermillion, Sangamon, DeKalb, Kankakee, LaSalle, Ogle, Randolph, Winnebego and Jackson counties)**	**$7,911.00**
Illinois Territory 04 - **(Remainder of State)**	**$5,800.00**

Increase limit factors: The applicable limit factor is determined by the chosen limit option on the application.

Limits of Liability	Increase Limit Factors
$100,000/$300,000	1.000
$200,000/$600,000	1.375
$250,000/$750,000	1.500
$500,000/$1,000,000	1.875
$1,000,000/$3,000,000	2.500
$2,000,000/$4,000,000	3.125

Claims-Made Step Factors:

Year	Claims-Made Step Factor
1	0.35
2	0.66
3	0.90
4	0.98
Mature	1.00

6th Month Rule: If the period between the retroactive date and the policy effective date is less than 6 months, rate at year 1. If the period is more than 6 months, rate at year 2, with each of the next consecutive claims made step increases applied at each renewal.

PROFESSIONAL SOLUTIONS INSURANCE COMPANY

STATE OF ILLINOIS

PHYSICIANS AND SURGEONS

PROFESSIONAL LIABILITY MANUAL

CLAIMS MADE COVERAGE

I. APPLICATION OF THIS MANUAL-ELIGIBILITY

This claims made program covers Physicians and Surgeons engaged in the rendering of professional services specific to their disciplines. Refer to the classification plan on page 9 for a description of each risk/rating category for physicians, surgeons.

Employees of health care professionals are also included as insureds for their acts while performing duties within the scope of their discipline while under the direction and supervision of the insured named in the coverage summary. Refer to page 11 for a listing of the ancillary employees who will be charged an additional premium for a separate limit of liability.

This program also provides coverage for both medical clinics and individual practicing physicians for the liability exposure of a partnership, corporation or professional association on either a separate or shared limit basis. Refer to the partnership, corporation or professional partnership section on page 11 for a description of the corporation rating factors.

II. PREMIUM DETERMINATION

1. Determine the base rate for the appropriate policy type and territory.
2. Refer to Classification Listing and apply the factor for the most appropriate class specialty being rated.
3. Apply the appropriate increase limit factor.
4. Apply the appropriate claims made step factor to reach the undiscounted premium.
5. Apply credit, if necessary, for new practitioner or part-time status (no further credits available, except for Size of Risk Credit).
6. Apply any credits for scheduled or experience rating.
7. Apply rounding.
8. Example Premium Calculation:

   Assume the full time undiscounted premium is $1,000 and no new practitioner or part-time status applies. Additional credits or debits will be applied in consecutive order.

   $1,000 x .95 = $950.00 (Schedule rating credit of 5%)
   $950.00 x .95 = $902.50 (Size of risk credit of 5%)
   $902.50 = $903.00 (Apply rounding)

III. POLICY PERIOD

The policy period shall be for a one-year term, unless in the middle of a claims made year.
In this instance, a short-term policy may be issued to expire on the member's original expiration date.
The policy period next following will be for one year.

IV. WHOLE DOLLAR PREMIUM RULE

All premiums shown on the policy and endorsements shall be rounded to the nearest whole dollar. If the premium is .50 or greater, round to next higher whole dollar. If the premium is .49 or less, round down. In the event of cancellation, the return premium shall be rounded to the nearest whole dollar. Rounding is the last step of the premium calculation.

Example: $1,234.30 is rounded to $1,234.
$1,234.60 is rounded to $1,235.

V. PRACTICE LOCATION

Practitioners who conduct a percentage of their practice located in another state or territory will be assessed additional premium, based upon the percentage of time spent in the other state or territory.

A. For insureds who practice in multiple states, the location of their primary practice will determine the base rate, with a premium debit of 25%, to be applied, based on their practice in the secondary state. The 25% debit will not be applied if the primary state's base rate is higher.

B. If more than one location of practice exists within the same state, the rate from the highest territory will be applied.

C. The insured must be licensed in all states where practicing.

VI. POLICY CANCELLATION

A. Cancellation By the Insured

The insured may cancel the policy by mailing or delivering notice to the Company stating when such cancellation shall be effective.

This policy will remain in full force and effect until its regular anniversary date unless the policy is cancelled sooner by the Company in accordance with the laws of the State of Illinois.

If the insured cancels the policy, earned premium shall be computed in accordance with the standard short rate tables and procedure. If the Company cancels the policy, earned premium shall be computed pro rata.

B. Cancellation/Non-Renewal By the Company

The Company may cancel or non-renew the policy in accordance with the insurance laws of the State of Illinois. Standard cancellation notice will be sent 60 days prior to cancellation, except that in the event of non-payment of premium, then not less than ten (10) days prior notice will be given.

VII. PREMIUM PAYMENT OPTIONS

1. Annual
2. Semi-Annual 50% prepayment required
3. Quarterly 25% prepayment required as the initial down payment with remaining payments of 25% each due at 3, 6 & 9 months after policy inception
4. Other payment options available upon request for large group accounts.

There is no installment fee charge or interest charged for utilizing the premium payment options. Additional premiums for policy changes occurring during the current policy term shall be computed pro rata of the annual premium. If there are no remaining installments, additional premium resulting from changes in coverage may be due immediately as a separate transaction.

VIII. RENEWALS

The policy will be renewed upon receipt of the required premium on or before the date of each successive policy period. The renewal premium shall be based on rates in effect on the renewal or anniversary date. The applicable forms and endorsements must be made a part of the policy. IX. SPECIAL PROVISIONS

A. Retroactive Coverage

This extension covers incidents which occurred subsequent to the prior carrier's retroactive date, but which are neither known nor reported as of the inception date of the replacement coverage written by Professional Solutions Insurance Company. The insured may apply for the Retroactive Date (shown on the Coverage Summary) that is equal to the retroactive date shown on the previous policy.

Premium for this extension is derived by rating the policy based upon the claims made step factor determined by using the previous carrier's retroactive date.

B. Basic Reporting Extension

This provision applies when coverage under the policy ends, either by action of the insured or the Company through cancellation, termination or non-renewal.

Under the circumstances stated above, the Company will provide a thirty (30) day Basic Reporting Extension which allows claims to be reported during this time that result from incidents that happened during the time the coverage was in force. The thirty (30) day Basic Reporting Extension does not apply if the insured purchases any subsequent insurance that replaces in whole or in part the coverage provided by this policy.

Within thirty (30) days of when the policy coverage terminates, the Company must advise the insured of the availability of Extended Reporting Coverage, the premium cost, and the importance of buying this additional coverage extension, commonly called "Tail Coverage".

The insured will have the greater of sixty (60) days from the date the coverage is terminated, or thirty (30) days from the date of notice, to accept the Extended Reporting Coverage in writing.

C. Extended Reporting Coverage, also called Tail Coverage

Extended Reporting Coverage will be provided for an unlimited time period with aggregate liability limits equal to or less than those of the expired coverage to report claims which arose from incidents that occurred when the coverage was in force. The liability limits provided by this option are the only limits that shall be applicable to the unlimited time period designated above. Extended Reporting Coverage can be applied to individual or entity policies.

The following factors will be applied to the undiscounted mature claims made premium in effect at the time the policy is terminated to calculate the extended reporting endorsement premium:

# of Years Completed in Claims Made Program	Tail Factor
1	0.92
2	1.43
3	1.70
4+	1.87

Professional Solutions Insurance Company cannot cancel the Extended Reporting Coverage except for non-payment of the additional premium.

The Company provides Extended Reporting Coverage automatically, at no additional charge, under the following circumstances:

1. The insured dies; or

2. The insured becomes permanently disables and is unable to continue their duties as a licensed insured; or

3. The insured retires. The insured must be age fifty-five (55) or older and have five (5) years of continuous coverage with Professional Solutions Insurance Company in order to qualify for free Extended Reporting Coverage.

D. Change in Rating Classification

In the event of a change in exposure or medical specialty of the practitioner, a charge reflecting the difference between the previous and such new exposure or specialty shall be calculated and collected at the time of such change unless:

1. otherwise eligible for Extended Reporting Coverage at no charge;

2. with regard to medical specialty, both the prior and the current specialty fall within the same class;
3. the exposure or medical specialty of the practitioner changed more than 4 years prior while insured under claims made coverage; or
4. the exposure or medical specialty of the practitioner changed while insured under occurrence coverage.

E. New Practitioner

A new practitioner is defined as a person who has completed his or her training within the previous six months, whose only contact with patients has been in the course of his or her training, and who has not been previously insured by Professional Solutions Insurance Company.

1st year	50% credit
2nd year	30% credit
3rd year	10% credit

Those who receive a new practitioner credit will not be eligible to receive any further credits, except for Size of Risk.

F. Part-Time Practitioner

A practitioner must practice 20 hours or less per week to become eligible for this credit. The insured must complete an application for part-time credit. If the application is approved, credits will be given by year according to the following schedule:

1st year	20% credit
2nd year	30% credit
3rd year	40% credit
4th year	50% credit

Those who receive a part-time practitioner credit will not be eligible to receive any further credits, except for Size of Risk.

G. Locum Tenens

Locum Tenens working in the place of an insured shall be provided coverage at no additional premium, for a period not to exceed forty-five (45) days per policy term. A completed application must be submitted to the company for prior underwriting approval.

X. SCHEDULED RATING

Professional Solutions Insurance Company will use the following schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of Professional Solutions Insurance Company uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the company.

The premium for a risk may be modified in accordance with the following, subject to a maximum modification of a 15% credit to a 40% debit to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this scheduled rating plan are subject to periodic review. The actual determination of the appropriate credit or debit will be determined through the underwriting review of the applicant's application.

1. Cumulative Years of Patient Experience:

Insureds who have demonstrated a stable, longstanding practice and/or significant degree of experience in their area of medicine.

2. **Classification Differences:**

   Characteristics of a particular insured that differentiate the insured from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.

3. **Implementation of Loss Control Procedures:**

   In order to qualify for this credit, the insured must demonstrate that credible loss control procedures have been properly implemented, and that these procedures will reduce the frequency and severity of claims.

4. **Number / Type of Patient Exposure:**

   Size and/or demographics of the patient population, which influences the frequency, and/or severity of claims.

XI. ADDITIONAL CREDITS

Size of Risk Credit

Insureds who are part of or employees of a professional association, corporation, or other group who become insureds of Professional Solutions Insurance Company shall be eligible for a credit based on the volume of premium brought to Professional Solutions Insurance Company. Insureds may receive this credit in addition to the other individual credits available. The size of risk credit will be applied to the undiscounted, total aggregate premium of the individual insureds, plus the corporation charge.

Premium	Credit
$100,001 - $200,000	.50%
$200,001 - $300,000	1.0%
$300,001 - $400,000	1.5%
$400,001 - $500,000	2.0%
$500,001 - $600,000	2.5%
$600,001 - $700,000	3.0%
$700,001 - $800,000	3.5%
$800,001 - $900,000	4.0%
$900,001 - $1,000,000	4.5%
over $1,000,000	5.0%

XII. EXPERIENCE RATING

Claims free credits

A claims free credit of 5% shall apply if the insured has achieved five (5) years without a claim, defined as $10,000 of incurred indemnity.

Claims debits

Claim debit factors – individual policy:

# OF CLAIMS IN 5 YEARS	FACTOR
1	1.000
2	1.500
3	2.500

Claim debit factors – partnership/corporate policy:

# OF CLAIMS IN 5 YEARS	FACTOR
1-2	1.000
3-4	1.500

The debit will not be based on an action that was filed or settled more than five (5) years immediately preceding the issuance or renewal of the policy.

Documentation, including copies of judgments, awards or stipulations of settlement will be requested and reviewed where available.

To obtain and verify experience applicable to each prospective insured, the Company will seek claim information from:

a. The applicant
b. The agent or broker
c. All previous insurers with respect to the experience period in question.

XIII. ENDORSED COVERAGES-Coverage Options

Partnership, Corporation or Professional Association With Shared Limits of Liability Endorsement-Form PSIC-CM-02

This endorsement provides a shared limit of liability to a partnership, corporation or professional association. Coverage is provided only to the extent of the entity's liability for the providing of professional services within the scope and course of employment by a person included within the definition of "Persons Insured" under the policy.

Partnership, Corporation or Professional Association With Separate Limits of Liability Endorsement-Form PSIC-CM-03

This endorsement provides a separate limit of liability to a partnership, corporation or professional association. Coverage is provided only to the extent of the entity's liability for the providing of professional services within the scope and course of employment by a person included within the definition of "Persons Insured" under the policy.

Additional Insured Endorsement-Form PSIC-CM-05

This endorsement provides coverage for an additional insured. This is an optional endorsement. The charge for this endorsement will be 15% of the base corporation/partnership premium.

Temporary Leave of Absence Endorsement-Form PSIC-CM-06

This endorsement may be utilized if an insured must take a leave of absence from their practice. Insureds who become disabled or take a leave of absence shall become eligible for suspension of coverage at a rate reduction of 90% of the otherwise applicable rate for the period of disability or leave of absence. The period must extend for a minimum length of sixty (60) days or more up to a maximum of one hundred eighty (180) days or until renewal. The lower premium will apply retroactively to the first day of the disability or leave.

This option provides continued protection to the provider who experiences a temporary interruption in his or her practice (subject to the stated eligibility requirements), for claims arising from acts, errors or omissions which occurred prior to the inception of the disability or leave. There is no coverage for acts, errors or omissions during the leave or disability period. Because the policy does not cancel, there is no need for the purchase of Extended Reporting Coverage (Tail).

If disabled, proof of disability must be submitted to the Company for approval, and the calculation of the credit will be on a pro rata basis for the period of the qualifying disability.

While on disability or leave, credit toward extended reporting vesting will continue to accrue, and the insured must continue to pay premiums when due.

Eligible Situations For Temporary Leave of Absence: Short-Term Disability, Maternity Leave, Military Leave or any other reason pre-approved by Professional Solutions Insurance Company – Does not apply to vacations

Extended Reporting Endorsement-Form PSIC-CM-07

This endorsement provides coverage for an unlimited time period with aggregate liability limits equal to or less than those of the expired coverage to report claims, which arose from incidents that occurred when the coverage was in force. The liability limits provided by this option are the only limits that shall be applicable to the unlimited time period designated above. This endorsement can be applied to group or entity policies.

Medical Laboratory Endorsement-Form PSIC-CM-10

This endorsement provides a shared limit of liability to a medical laboratory facility. The premium for the endorsement is based on the following:

a. at no additional charge if such laboratory is not a separate entity. Coverage is limited to the testing of the insured's own patients.

b. as an additional insured at 25% of the mature Class 1 rate, if such laboratory is a separate entity. Coverage is limited to the testing of the insured's own patients.

Specialty Classification Amendment Endorsement-Form PSIC-CM-11

This endorsement will be attached to the policy if the insured amends their medical specialty during the policy period. This endorsement will extend coverage for claims that are reported under the insured's previous medical specialty. The premium will be adjusted based on the change of the specialty classification.

XIV. Classification Plan – Refer to rate sheet for base rate information.

ISO Specialty Codes M.D.	ISO Specialty Codes D.O.	Class	Description	FACTOR
80230		1	Aerospace Medicine	0.650
80254		1	Allergy/Immunology	0.650
80256		1	Dermatology - No Surgery	0.650
80240		1	Forensic Medicine	0.650
80248		1	Nutrition	0.650
80233		1	Occupational Medicine	0.650
80263		1	Ophthalmology - No Surgery	0.650
80235		1	Physiatry/Physical Medicine	0.650
80231		1	Preventive Medicine - No Surgery	0.650
80251		1	Psychosomatic Medicine	0.650
80236		1	Public Health	0.650
80237		2	Diabetes No Surgery	0.850
80238		2	Endocrinology - No Surgery	0.850
80243		2	Geriatrics - No Surgery	0.850
80244		2	Gynecology - No Surgery	0.850
80260		2	Nephrology - No Surgery	0.850
80262		2	Nuclear Medicine	0.850
80268		2	Physicians - No Surgery N.O.C.	0.850
80995		2	Podiatry - Soft Tissue	0.850
80249		2	Psychiatry including child	0.850
80252		2	Rheumatology - No Surgery	0.850
80255		3	Cardiovascular Disease - No Surgery	1.000
80420		**3**	**Family Phys. Or Gen. Prac. - No Surgery**	**1.000**
80241		3	Gastroenterology - No Surgery	1.000
80245		3	Hematology - No Surgery	1.000
80246		3	Infectious Diseases - No Surgery	1.000
80258		3	Laryngology - No Surgery	1.000
80259		3	Neoplastic Diseases - No Surgery	1.000
80302		3	Oncology No Surgery	1.000
80264		3	Otology - No Surgery	1.000
80265		3	Otorhinolaryngology - No Surgery	1.000
80266		3	Pathology No Surgery	1.000
80269		3	Pulmonary Diseases - No Surgery	1.000
80247		3	Rhinology - No Surgery	1.000
80257		4	Internal Medicine - No Surgery	1.250
80287		4	Nephrology - Minor Surgery	1.250
80301		4	Oncology - Minor Surgery	1.250
80289		4	Ophthalmology - Minor Surgery	1.250
80114		4	Opthalmology - Surgery	1.250
80267		4	Pediatrics - No Surgery	1.250
80298		4	Pulmonary Diseases - Minor Surgery	1.250
80281		5	Cardiovascular Disease - Minor Surgery	1.500
80282		5	Dermatology - Minor Surgery	1.500

80271	5	Diabetes - Minor Surgery	1.500
80272	5	Endocrinology - Minor Surgery	1.500
80274	5	Gastroenterology - Minor Surgery	1.500
80276	5	Geriatrics - Minor Surgery	1.500
80277	5	Gynecology - Minor Surgery	1.500
80278	5	Hematology - Minor Surgery	1.500
80279	5	Infectious Diseases - Minor Surgery	1.500
80284	5	Internal Medicine - Minor Surgery	1.500
80285	5	Laryngology - Minor Surgery	1.500
80261	5	Neurology - No Surgery	1.500
80290	5	Otology - Minor Surgery	1.500
80291	5	Otorhinolaryngology - Minor Surgery	1.500
80294	5	Physicians - Minor Surgery N.O.C.	1.500
80253	5	Radiology Diagnostic - No Surgery	1.500
80270	5	Rhinology - Minor Surgery	1.500
80145	5	Urological Surgery	1.500
80151	6	Anesthesiology	1.650
80421	6	Family Phys. Or Gen. Prac.- Minor Surgery	1.650
80283	6	Intensive Care Medicine	1.650
80286	6	Neoplastic Diseases - Minor Surgery	1.650
80288	6	Neurology - Minor Surgery	1.650
80292	6	Pathology - Minor Surgery	1.650
80293	6	Pediatrics - Minor Surgery	1.650
80101	7	Broncho-Esophagology	2.150
80103	7	Endocrinology Surgery	2.150
80104	7	Gastroenterology Surgery	2.150
80105	7	Geriatrics Surgery	2.150
80804	7	Neonatal/Perinatal Medicine	2.150
80108	7	Nephrology Surgery	2.150
80159	7	Otorhinolaryngology - No Plastic Surgery	2.150
80280	7	Radiology Diagnostic - Minor Surgery	2.150
80115	8	Colon and Rectal Surgery	2.500
80106	8	Laryngology Surgery	2.500
80107	8	Neoplastic Surgery	2.500
80164	8	Oncology Surgery	2.500
80158	8	Otology	2.500
80136	8	Radiology Including Radiation Therapy	2.500
80160	8	Rhinology Surgery	2.500
80102	9	Emergency Medicine - No Major Surgery	3.000
80117	9	General Prac. or Family Prac. Surgery	3.000
80143	9	General Surgery	3.000
80169	10	Hand Surgery	3.350
89154	10	Orthopedic Surgery - No Spine	3.350
80155	10	Otorhinolaryngology w/Plastic Surgery	3.350
80166	11	Abdominal Surgery	3.750
80157	11	Emergency Medicine Surgery	3.750
80167	11	Gynecology Surgery	3.750
80170	11	Head and Neck Surgery	3.750
80141	12	Cardiac Surgery	4.500
80150	12	Cardiovascular Disease Surgery	4.500
80154	12	Orthopedic Surgery - Including Spine	4.500
80156	12	Plastic N.O.C. Surgery	4.500
80144	12	Thoracic Surgery	4.500

80171	12	Traumatic Surgery	4.500
80146	12	Vascular Surgery	4.500
80153	13	Obstetrics Gynecology Surgery	5.500
80168	13	Obstetrics Surgery	5.500
80152	14	Neurology Surgery	6.750

Ancillary Provider Rating:

Ancillary Provider	Separate Limits Factor
Physician Assistant	0.200
Surgical Assistant	0.200
Nurse Anesthetist	0.560
Nurse Practitioner	0.200
Psychologist	0.250
Emergency Medical Technicians/Paramedics	0.300
H/L Perfusionist	0.300
O.R. Technician	0.300
Nurse Midwife No Delivery	0.750
Nurse Midwife Delivery	1.500

XV. Partnership-Corporation-Professional Association Coverage

A. Shared Limits of Liability:

Coverage for partnerships, corporations, or professional associations may be written with a shared limit of liability. The premium charge for shared limits will be 5% of the total undiscounted liability premium for all practitioners.

B. Separate Limits of Liability:

Coverage for partnerships, corporations, or professional associations may be written with a separate limit of liability. The premium charge for separate limits will be a percentage of the total undiscounted liability premium for all practitioners. The percentage will vary based on the number of insureds in the corporation.

Number of Insureds	Percent
2-5	15.0%
6-9	12.0%
10-19	9.0%
20-49	7.0%
50 or more	5.0%

XVI. Rates

Physicians and Surgeons Mature Claims Made Rate (for Class 3 provider @ 100/300 limits)

Illinois Territory 01 - **(Cook, Madison and St. Clair counties)**	**$12,110.00**
Illinois Territory 02 -	**$8,967.00**
(DePage, Kane, Lake, McHenry and Will counties)	
Illinois Territory 03 - **Champaign, Macon, Jackson, Vermillion, Sangamon, DeKalb, Kankakee, LaSalle, Ogle, Randolph, Winnebego and Jackson counties)**	**$7,911.00**
Illinois Territory 04 - **(Remainder of State)**	**$5,800.00**

Increase limit factors: The applicable limit factor is determined by the chosen limit option on the application.

Limits of Liability	Increase Limit Factors
$100,000/$300,000	1.000
$200,000/$600,000	1.375
$250,000/$750,000	1.500
$500,000/$1,000,000	1.875
$1,000,000/$3,000,000	2.500
$2,000,000/$4,000,000	3.125

Claims-Made Step Factors:

Year	Claims-Made Step Factor
1	0.35
2	0.66
3	0.90
4	0.98
Mature	1.00

6th Month Rule: If the period between the retroactive date and the policy effective date is less than 6 months, rate at year 1. If the period is more than 6 months, rate at year 2, with each of the next consecutive claims made step increases applied at each renewal.

Contact Person:
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.nois Division of Insurance
Review Requirements Checklist

20 West Washington Street
Springfield, IL 62767-0001

Effective as of 8/25/06

Line(s) of Business	Code(s)	
___**MEDICAL MALPRACTICE**	**11.0000**	***This checklist is for rate/rule filings only. See separate form checklist.
_X_ Claims Made	11.1000	
___Occurrence	11.2000	

Line(s) of Insurance	Code(s)	Line(s) of Insurance	Code(s)	Line(s) of Insurance	Code(s)
___Acupuncture	11.0001	___Hospitals	11.0009	___Optometry	11.0019
___Ambulance Services	11.0002	___Professional Nurses	11.0032	___Osteopathy	11.0020
___Anesthetist	11.0031	___Nurse – Anesthetists	11.0010	___Pharmacy	11.0021
___Assisted Living Facility	11.0033	___Nurse – Lic. Practical	11.0011	___Physical Therapy	11.0022
___Chiropractic	11.0003	___Nurse – Midwife	11.0012	_X_ Physicians & Surgeons	11.0023
___Community Health Center	11.0004	___Nurse – Practitioners	11.0013	___Physicians Assistants	11.0024
___Dental Hygienists	11.0005	___Nurse – Private Duty	11.0014	___Podiatry	11.0025
___Dentists	11.0030	___Nurse – Registered	11.0015	___Psychiatry	11.0026
___Dentists – General Practice	11.0006	___Nursing Homes	11.0016	___Psychology	11.0027
___Dentists – Oral Surgeon	11.0007	___Occupational Therapy	11.0017	___Speech Pathology	11.0028
___Home Care Service Agencies	11.0008	___Ophthalmic Dispensing	11.0018	___Other	11.0029

Illinois Insurance Code Link	Illinois Compiled Statutes Online	
Illinois Administrative Code Link	Administrative Regulations Online	
Product Coding Matrix Link	Product Coding Matrix	
NAIC Uniform Transmittal Form	50 IL Adm. Code 929 NAIC Uniform Transmittal Form	If insurers wish to use the NAIC Uniform Transmittal form in lieu of a cover letter/ explanatory memorandum, the Division will accept such form, as long as all information required in the "Cover Letter & Explanatory Memorandum" section below are properly included.
NAIC Self-Certification Pilot Program	Newsletter Article regarding Division's Participation Self-Certification form	If an authorized company officer completes the Self-Certification form, and submits such form as the 1st page of the filing, the Division will expedite review of the filing ahead of all other filings received to date. The Division will track company compliance with the laws, regulations, bulletins, and this checklist and report such information to the NAIC.
Location of Standard within Filing Column	See checklist format below.	To expedite review of your filing, use this column to indicate location of the standard within the filing (e.g. page #, section title, etc.)
Description of Review Standards Requirements Column	See checklist format below.	These brief summaries do not include all requirements of all laws, regulations, bulletins, or requirements, so review actual law, regulation, bulletin, or requirement for details to ensure that forms are fully compliant before filing with the Division of Insurance.

FILING REQUIREMENTS FOR FORM FILINGS	REFERENCE	DESCRIPTION OF REVIEW STANDARD REQUIREMENT	LOCATION OF STANDARD WITHIN FILING
See separate form filing checklist.		To assist insurers in submitting compliant medical liability rate/rule filings as a result of newly-passed PA94-677 (SB475), the Division has created this separate, comprehensive rate/rule filing checklist for medical liability filings. Please see the separate form filing checklist for requirements related to medical liability forms.	N/A
GENERAL FILING REQUIREMENTS FOR ALL RATE/ RULE FILINGS			
LINE OF AUTHORITY			
Must have proper Class and Clause authority to conduct this line of business in Illinois.	215 ILCS 5/4 List of Classes/ Clauses	To write Medical Liability insurance in Illinois, companies must be licensed to write: 1. Class 2, Clause (c)	OK
RATES AND RULES REQUIRED TO BE FILED			
Rates/Rules Must be Filed Separately from Forms			
Insurers shall make separate filings for rate/ rules and for forms/ endorsements, etc.		The laws and regulations for medical liability forms/ endorsements and the laws for medical liability rates/ rules are different and each must be reviewed according to its own set of laws/regulations/procedures. Therefore, insurers are required to file forms and rates/rules separately. For requirements regarding form filings, see separate form filing checklist.	OK
New Insurers			
New insurers must file their rates, rules, plans for gathering statistics, etc. upon commencement of business.	215 ILCS 5/155.18 50 IL Adm. Code 929	"New Insures" are insurers who are: • New to Illinois. • New writers of medical liability insurance in Illinois. • Writing a new Line of Insurance listed on Page 1 of this checklist, New insurers must file the following: a) Medical liability insurance rate manual, including all rates. b) Rules, including underwriting rule manuals which contain rules for applying rates or rating plans, c) Classifications and other such schedules used in writing medical liability insurance. d) Statement regarding whether the insurer:	N/A

		• Has its own plan for the gath. ig of medical liability statistics; or • Reports its medical liability statistics to a statistical agent (and if so, which agent). The Director, at any time, may request a copy of the insurer's statistical plan or request the insurer to provide written verification of membership and reporting status from the insurer's reported statistical agency. Insurers are instructed to review all requirements in this checklist, including the requirements for applicable actuarial documentation, as well as all medical liability laws and regulations, to ensure that the filing contains all essential elements before submitting the filing to the Division.	N/A
Amendments to Initial Rate/Rule Filings			
After a new insurer has filed the rates/rules/ information described above, insurers must file rates/rules, or advise of changes to statistical plans, as often as they are amended.	215 ILCS 5/155.18 50 IL Adm. Code 929	After a new insurer has filed the rates/rules/information described above, insurers must file rates/rules/rating schedules (as described above for new business) as often as such filings are changed or amended, or when any new rates or rules are added. Any change in premium to the company's insureds as a result of a change in the company's base rates or a change in its increased limits factors shall constitute a change in rates and shall require a filing with the Director. Insurers shall also advise the Director if its plans for the gathering of statistics has changed, or if the insurer has changed statistical agents. The Director, at any time, may request a copy of the insurer's statistical plan or request the insurer to provide written verification of membership and reporting status from the insurer's reported statistical agency. Insurers are instructed to review all requirements in this checklist, including the requirements for applicable actuarial documentation, as well as all medical liability laws and regulations, to ensure that the filing contains all essential elements before submitting the filing to the Division.	OK
EFFECTIVE DATES OF RATE/RULE FILINGS			
Illinois is "file and use" for medical liability rates and rules.	215 ILCS 5/155.18 50 IL Adm. Code 929	A rate/rating plan/rule filing shall go into effect no earlier than the date the filing is received by the Division of Insurance, Property & Casualty Compliance Section, except as otherwise provided in Section 155.18.	OK
ADOPTIONS OF ADVISORY ORGANIZATION FILINGS			
Insurer must file all rates and rules on its own behalf.	50 IL Adm. Code 929	Although Rule 929 allows for insurers to adopt advisory organization rule filings, advisory organizations no longer file rules in Illinois.	N/A
COPIES, RETURN ENVELOPES, ETC.			

Requirement for duplicate copies and return envelope with adequate postage.	50 IL Adm. Cc 929	Insurers that desire a stamped retur copy of the filing or submission letter must submit a duplicate copy of the filing/letter, along with a return envelope large enough and containing enough postage to accommodate the return filing.	OK
COVER LETTER & EXPLANATORY MEMORANDUM			
Two copies of a submission letter are required, and the submission letter must contain the information specified. "Me too" filings are not allowed. Use of NAIC Uniform Transmittal form is acceptable as long as all required information is included.	215 ILCS 5/155.18 50 IL Adm. Code 929 Company Bulletin 88-53 Actuarial Certification Form NAIC Uniform Transmittal Form	All filings must be accompanied by a submission letter which includes all of the following information: 1) Exact name of the company making the filing. 2) Federal Employer Identification Number (FEIN) of the company making the filing. 3) Unique filing identification number – may be alpha, numeric, or both. Each filing number must be unique within a company and may not be repeated on subsequent filings. If filing subsequent revisions to a pending filing, use the same filing number as the pending filing or the revision(s) will be considered a new filing. 4) Identification of the classes of medical liability insurance to which the filing applies (for identifying classes, refer to Lines of Insurance shown on Page 1 of this checklist, in compliance with the NAIC Product Coding Matrix). 5) Notification of whether the filing is new or supersedes a present filing. If filing supersedes a present filing, insurer must identify all changes in superseding filings, and all superseded filings, including the following information: • Copy of the complete rate/rule manual section(s) being changed by the filing with all changes clearly highlighted or otherwise identified. • Written statement that all changes made to the superseded filing have been disclosed. • List of all pages that are being completely superseded or replaced with new pages. • List of pages that are being withdrawn and not being replaced. • List of new pages that are being added to the superseded filing. • Copies of all manual pages that are affected by the new filing, including but not limited to subsequent pages that are amended solely by receiving new page numbers. 6) Effective date of use. 7) Actuarial certification (see Actuarial Certification section below). Insurers may use their own form or may use the sample form developed by the Division. 8) Statement that the insurer, in offering, administering, or applying the filed rate/rule manual and/or any amended provisions, does not unfairly discriminate.	OK

		Companies under the same ownership or general management are required to make separate, individual company filings. Company Group ("Me too") filings are unacceptable. If insurers wish to use the NAIC Uniform Transmittal form in lieu of a cover letter/explanatory memorandum, the Division will accept such form, as long as all information required in this section is properly included.	OK
FORM RF-3 Summary Sheet			
For any rate change, duplicate copies of Form RF-3 must be filed, no later than the effective date.	50 IL Adm. Code 929 Form RF-3 Summary Sheet	For any rate level change, insurers must file two copies of Form RF-3 (Summary Sheet) which provides information on changes in rate level based on the company's premium volume, rating system, and distribution of business with respect to the classes of medical liability insurance to which the rate revision applies. Such forms must be received by the Division's Property & Casualty Compliance Section no later than the stated effective date of use. Insurers must report the rate change level and premium volume amounts on the "Other" Line and insert the words "Medical Liability" on the "Other" descriptive line. Do not list the information on the "Other Liability" line. If the Medical Liability premium is combined with any other Lines of Business (e.g. CGL, commercial property, etc.), the insurer must report the effect of rate changes to each line separately on the RF-3, indicating the premium written and percent of rate change for each line of business. The RF-3 form must indicate whether the information is "exact" or "estimated."	N/A
PAYMENT PLANS			
Quarterly premium payment installment plan required as prescribed by the Director.	215 ILCS 5/155.18	A company writing medical liability insurance in Illinois shall offer to each of its medical liability insureds the option to make premium payments in quarterly installments as prescribed by and filed with the Director. Such option must be offered in the initial offer of the policy or in the first policy renewal occurring after January 1, 2006. Thereafter, the insurer need not offer the option, but if the insured requests it, must make it available. Such plans are subject to the following minimum requirements: • May not require more than 40% of the estimated total premium to be paid as the initial payment; • Must spread the remaining premium equally among the 2nd, 3rd, and 4th installments, with the maximum set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively; • May not apply interest charges; • May include an installment charge or fee of no	Section VII page 3

		more than the lesser of 1% of the al premium or $25; • Must spread any additional premium resulting from changes to the policy equally over the remaining installments, if any. If there are no remaining installments, the additional premium may be billed immediately as a separate transaction; and • May, but is not required to offer payment plan for extensions of a reporting period, or to insureds whose annual premiums are less than $500. However, if offered to either, the plan must be made available to all within that group.	Section VII page 3
DEDUCTIBLES			
Deductible plans should be filed if offered.	215 ILCS 5/155.18	A company writing medical liability insurance in Illinois is encouraged, but not required, to offer the opportunity for participation in a plan offering deductibles to its medical liability insureds. Any such plan shall be contained in a filed rate/rule manual section entitled "Deductibles Offered" or substantially similar title. If an insurer uses a substantially similar title, the Rate/Rule Submission Letter or NAIC Uniform Transmittal form must indicate the name of the section that applies.	N/A
DISCOUNTS			
Premium discount for risk management activities should be filed if offered.	215 ILCS 5/155.18	A company writing medical liability insurance in Illinois is encouraged, but not required, to offer their medical liability insureds a plan providing premium discounts for participation in risk management activities. Any such plan shall be contained in a filed rate/rule manual section entitled "Risk Management Activities Discounts" or substantially similar title. If an insurer uses a substantially similar title, the Rate/Rule Submission Letter or NAIC Uniform Transmittal form must indicate the name of the section that applies.	Section X page 6
CLAIMS MADE REQUIREMENTS			
Extended reporting period (tail coverage) requirements.	215 ILCS 5/143(2) Company Bulletin 88-50	When issuing claims-made medical liability insurance policies, insurers must include the following specific information in their rate/rule manuals: • Offer of an extended reporting period (tail coverage) of at least 12 months. The rate/rule manual must specify whether the extended reporting period is unlimited or indicate its term (i.e. number of years).*** • Cost of the extended reporting period, which must be priced as a factor of one of the following:*** o the last 12 months' premium. o the premium in effect at policy issuance. o the expiring annual premium. • List of any credits, discounts, etc. that will be added or removed when determining the final extended reporting period premium. • Insurer will inform the insured of the extended reporting period premium at the time the last policy is purchased. The insurer may not wait until the insured	Section IX page 4

		requests to purchase the extend[illegible]eporting period coverage to tell the insured what the premium will be or how the premium would be calculated. • Insurer will offer the extended reporting period when the policy is terminated for any reason, including non-payment of premium, and whether the policy is terminated at the company's or insured's request. • Insurer will allow the insured 30 days after the policy is terminated to purchase the extended reporting period coverage.*** • Insurer will trigger the claims made coverage when notice of claim is received and recorded by the insured or company, whichever comes first. ***If the medical liability coverage is combined with other professional or general liability coverages, the medical liability insurer must meet all of the above requirements, except those indicated with ***, in which case, the insurer must: • Offer free 5-year extended reporting period (tail coverage) or • Offer an unlimited extended reporting period with the limits reinstated (100% of aggregate expiring limits for the duration) • Cap the premium at 200% of the annual premium of the expiring policy; and • Give the insured a free-60 day period after the end of the policy to request the coverage.	Section IX page 4
GROUP MEDICAL LIABILITY			
Group medical liability insurance is not specifically allowed under the Illinois Insurance Code.	50 IL Adm. Code 906	Part 906 of the Illinois Administrative Code prohibits writing of group casualty (liability) insurance unless specifically authorized by statute. The Illinois Insurance Code does not specifically authorize the writing of group medical liability insurance.	N/A
CANCELLATION & NONRENEWAL PROVISION REQUIREMENTS			
If rate/rule manuals contain language pertaining to cancellation or nonrenewal, must comply with all cancellation/ nonrenewal laws.	See Medical Liability Forms Checklist for Specific Information about Illinois Cancellation & Nonrenewal Laws and Regulations,	If a rate or rule manual contains language pertaining to cancellation or nonrenewal of any medical liability insurance coverage, such provisions must comply with all cancellation and nonrenewal provisions of the Illinois Insurance Code, including but not limited to the following: 143.10, 143.16, 143.16a, 143.17a. See Medical Liability Forms Checklist for Specific Information about Illinois Cancellation & Nonrenewal Laws and Regulations,	Section VI page 3
ACTUARIAL REVIEW REQUIREMENTS			

Rates shall not be excessive, inadequate, or unfairly discriminatory.	215 ILCS 5/15 8	In the making or use of rates pertain to all classes of medical liability insurance, rates shall not be excessive, or inadequate, nor shall they be unfairly discriminatory. Rate and rule manual provisions should be defined and explained in a manner that allows the Division to ascertain whether the provision could be applied in an unfairly discriminatory manner. For example, if a rate/rule manual contains ranges of premiums or discounts, the provision must specify the criteria to determine the specific premium/discount an insured or applicant would receive. The Director may, by order, adjust a rate or take any other appropriate action at the conclusion of a public hearing.	N/A
PRICING			
Insurers shall consider certain information when developing medical liability rates.	215 ILCS 5/155.18	Consideration shall be given, to the extent applicable, to past and prospective loss experience within and outside this State, to a reasonable margin for underwriting profit and contingencies, to past and prospective expenses both countrywide and those especially applicable to Illinois, and to all other factors, including judgment factors, deemed relevant within and outside Illinois. Consideration may also be given in the making and use of rates to dividends, savings or unabsorbed premium deposits allowed or returned by companies to their policyholders, members or subscribers. The systems of expense provisions included in the rates for use by any company or group of companies may differ from those of other companies or groups of companies to reflect the operating methods of any such company or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof.	N/A
Minimum Premium Rules			
Insurers may group or classify risks for establishing rates and minimum premiums.	215 ILCS 5/155.18	Risks may be grouped by classifications for the establishment of rates and minimum premiums.	N/A
"A" RATED RISKS			
Individual Risk Rating			

Risks may be rated on an individual basis as long as all provisions required in Section 155.18 are met.	215 ILCS 5/155.18	Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any difference among risks that have a probable effect upon losses or expenses. Such classifications or modifications of classifications of risks may be established based upon size, expense, management, individual experience, location or dispersion of hazard, or any other reasonable considerations, and shall apply to all risks under the same or substantially the same circumstances or conditions. The rate for an established classification should be related generally to the anticipated loss and expense factors or the class.	N/A
RISK CLASSIFICATION			
Risks may be grouped by classifications.	215 ILCS 5/155.18	Risks may be grouped by classifications for the establishment of rates and minimum premiums.	N/A
Rating decisions based solely on domestic violence.	215 ILCS 5/155.22b	No insurer may that issues a property and casualty policy may use the fact that an applicant or insured incurred bodily injury as a result of a battery committed against him/her by a spouse or person in the same household as a sole reason for a rating decision.	N/A
Unfair methods of competition or unfair or deceptive acts or practices defined.	215 ILCS 5/424(3)	It is an unfair method of competition or unfair and deceptive act or practice if a company makes or permits any unfair discrimination between individuals or risks of the same class or of essentially the same hazard and expense element because of the race, color, religion, or national origin of such insurance risks or applicants.	N/A
Procedure as to unfair methods of competition or unfair or deceptive acts or practices not defined.	215 ILCS 5/429	Outlines the procedures the Director follows when he has reason to believe that a company is engaging in unfair methods of competition or unfair or deceptive acts or practices.	N/A
Territorial Definitions			
Rate/rule manuals must contain correct and adequate definitions of Illinois territories.	215 ILCS 5/155.18	When an insurer's rate/rule program includes differing territories within the State of Illinois, rate/rule manuals must contain correct and adequate definitions of those territories, and that all references to the territories or definitions are accurate, so the Division does not need to request additional information.	Section XVI page 13
ACTUARIAL SUPPORT INFORMATION REQUIRED			
ACTUARIAL CERTIFICATION			
Actuarial certification must accompany all rate filings and all rule filings that affect rates.	215 ILCS 5/155.18 50 IL Adm. Code 929 Actuarial Certification Form	Every rate and/or rating rule filing must include a certification by an officer of the company <u>and</u> a qualified actuary that the company's rates and/or rules are based on sound actuarial principles and are not inconsistent with the company's experience. Insurers may use their own form or may use the sample form created by the Division.	OK See Certification
ACTUARIAL OR STATISTICAL INFORMATION			

Director may request actuarial and statistical information.	215 ILCS 5/15 8 50 IL Adm. Code 929	The Director may require the filing o. tistical data and any other pertinent information necessary to determine the manner of promulgation and the acceptability or unacceptability of a filing for rules, minimum premiums, rates, forms or any combination thereof. If the Director requests information or statistical data to determine the manner the insurer used to set the filed rates and/or to determine the reasonableness of those rates, as well as the manner of promulgation and the acceptability or unacceptability of a filing for rules, minimum premiums, or any combination thereof, the insurer shall provide such data or information within 14 calendar days of the Director's request.	OK
Explanatory Memorandum			
Insurers shall include actuarial explanatory memorandum with any rate filing, as well as any rule filing that affects the ultimate premium.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include actuarial explanatory memorandum with any rate filing, as well as any rule filing that affects the ultimate premium. The explanatory memorandum shall contain, at minimum, the following information: • Explanation of ratemaking methodologies. • Explanations of specific changes included in the filing. • Narrative that will assist in understanding the filing.	OK See Cover Letter
Summary of Effects Exhibit			
Insurers shall include an exhibit illustrating the effect of each change and calculation indicating how the final effect was derived.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit illustrating the effect of each individual change being made in the filing (e.g. territorial base rates, classification factor changes, number of exposures affected by each change being made, etc.), and include a supporting calculation indicating how the final effect was derived.	N/A
Actuarial Indication			
Insurers shall include actuarial support justifying the overall changes being made.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include actuarial support justifying the overall changes being made, including but not limited to: • Pure premiums (if used). • Earned premiums. • Incurred losses. • Loss development factors. • Trend factors. • On-Level factors. • Permissible loss ratios, etc.	N/A
Loss Development Factors and Analysis			
Insurers shall include support for loss development factors and analysis.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include actuarial support for loss development factors and analysis, including but not limited to loss triangles and selected factors, as well as support for the selected factors.	N/A
Ultimate Loss Selections			
Insurers shall include support for ultimate loss selections.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for ultimate loss selections, including an explanation of selected losses if results from various methods differ significantly.	N/A
Trend Factors and Analysis			

Insurers shall include support for trend factors and analysis.	215 ILCS 5/15 8 50 IL Adm. Code 929	Insurers shall include support for tre actors and analysis, including loss and premium trend exhibits demonstrating the basis for the selections used.	N/A
On-Level Factors and Analysis			
Insurers shall include support for on-level factors and analysis.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for on-level factors and analysis, including exhibits providing on-level factors and past rate changes included in calculations.	N/A
Loss Adjustment Expenses			
Insurers shall include support for loss adjustment expenses.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for loss adjustment expenses, including exhibits providing documentation to support factors used for ALAE and ULAE. If ALAE is included in loss development analysis, no additional ALAE exhibit is required.	N/A
Expense Exhibit			
Insurers shall include an expense exhibit. Insurers may use expense provisions that differ from those of other companies or groups of companies.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit indicating all expenses used in the calculation of the permissible loss ratio, including explanations and support for selections. The systems of expense provisions included in the rates for use by any company or group of companies may differ from those of other companies or groups of companies to reflect the operating methods of any such company or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof.	N/A
Investment Income Calculation			
Insurers shall include an exhibit for investment income calculation.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit demonstrating the calculation for the investment income factor used in the indication.	N/A
Profit and Contingencies Calculation			
Insurers shall include an exhibit for profit and contingencies load.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit illustrating the derivation of any profit and contingencies load.	N/A
Credibility Standard Used			
Insurers shall include the number of claims being used to calculate the credibility factor.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers should include the number of claims being used to calculate the credibility factor. If another method of calculating credibility is utilized, insurers should include a description of the method used.	N/A
Other Actuarial Information Required			
Insurers must include the information described in this section.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall also include the following information: • All actuarial support/justification for all rates being changed, including but not limited to changes in: ○ Base rates; ○ Territory definitions; ○ Territory factor changes; ○ Classification factor changes; ○ Classification definition changes; ○ Changes to schedule credits/debits, etc. • Exhibits containing current and proposed rates/	OK See Certification

		factors for all rates and classifica factors, etc. being changed. • Any exhibits necessary to support the filing that are not mentioned elsewhere in this checklist.	OK See Certification
Schedule Rating			
Insurers must include the described information described at right.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers should include appropriate actuarial justification when filing schedule rating plans and/or changes to schedule rating plans.	Section X pages 5-6

PROFESSIONAL SOLUTIONS INSURANCE COMPANY

STATE OF ILLINOIS

PHYSICIANS AND SURGEONS

PROFESSIONAL LIABILITY MANUAL

CLAIMS MADE COVERAGE

I. APPLICATION OF THIS MANUAL-ELIGIBILITY

This claims made program covers Physicians and Surgeons engaged in the rendering of professional services specific to their disciplines. Refer to the classification plan on page 9 for a description of each risk/rating category for physicians, surgeons.

Employees of health care professionals are also included as insureds for their acts while performing duties within the scope of their discipline while under the direction and supervision of the insured named in the coverage summary. Refer to page 11 for a listing of the ancillary employees who will be charged an additional premium for a separate limit of liability.

This program also provides coverage for both medical clinics and individual practicing physicians for the liability exposure of a partnership, corporation or professional association on either a separate or shared limit basis. Refer to the partnership, corporation or professional partnership section on page 11 for a description of the corporation rating factors.

II. PREMIUM DETERMINATION

1. Determine the base rate for the appropriate policy type and territory.
2. Refer to Classification Listing and apply the factor for the most appropriate class specialty being rated.
3. Apply the appropriate increase limit factor.
4. Apply the appropriate claims made step factor to reach the undiscounted premium.
5. Apply credit, if necessary, for new practitioner or part-time status (no further credits available, except for Size of Risk Credit).
6. Apply any credits for scheduled or experience rating.
7. Apply rounding.
8. Example Premium Calculation:

   Assume the full time undiscounted premium is $1,000 and no new practitioner or part-time status applies. Additional credits or debits will be applied in consecutive order.

   $1,000 x .95 = $950.00 (Schedule rating credit of 5%)
   $950.00 x .95 = $902.50 (Size of risk credit of 5%)
   $902.50 = $903.00 (Apply rounding)

III. POLICY PERIOD

The policy period shall be for a one-year term, unless in the middle of a claims made year. In this instance, a short-term policy may be issued to expire on the member's original expiration date. The policy period next following will be for one year.

IV. WHOLE DOLLAR PREMIUM RULE

All premiums shown on the policy and endorsements shall be rounded to the nearest whole dollar. If the premium is .50 or greater, round to next higher whole dollar. If the premium is .49 or less, round down. In the event of cancellation, the return premium shall be rounded to the nearest whole dollar. Rounding is the last step of the premium calculation.

Example: $1,234.30 is rounded to $1,234.
$1,234.60 is rounded to $1,235.

V. PRACTICE LOCATION

Practitioners who conduct a percentage of their practice located in another state or territory will be assessed additional premium, based upon the percentage of time spent in the other state or territory.

A. For insureds who practice in multiple states, the location of their primary practice will determine the base rate, with a premium debit of 25%, to be applied, based on their practice in the secondary state. The 25% debit will not be applied if the primary state's base rate is higher.

B. If more than one location of practice exists within the same state, the rate from the highest territory will be applied.

C. The insured must be licensed in all states where practicing.

VI. POLICY CANCELLATION

A. Cancellation By the Insured

The insured may cancel the policy by mailing or delivering notice to the Company stating when such cancellation shall be effective.

This policy will remain in full force and effect until its regular anniversary date unless the policy is cancelled sooner by the Company in accordance with the laws of the State of Illinois.

If the insured cancels the policy, earned premium shall be computed in accordance with the standard short rate tables and procedure. If the Company cancels the policy, earned premium shall be computed pro rata.

B. Cancellation/Non-Renewal By the Company

The Company may cancel or non-renew the policy in accordance with the insurance laws of the State of Illinois. Standard cancellation notice will be sent 60 days prior to cancellation, except that in the event of non-payment of premium, then not less than ten (10) days prior notice will be given.

VII. PREMIUM PAYMENT OPTIONS

1. Annual
2. Semi-Annual — 50% prepayment required
3. Quarterly — 25% prepayment required as the initial down payment with remaining payments of 25% each due at 3, 6 & 9 months after policy inception
4. Other payment options available upon request for large group accounts.

There is no installment fee charge or interest charged for utilizing the premium payment options. Additional premiums for policy changes occurring during the current policy term shall be computed pro rata of the annual premium. If there are no remaining installments, additional premium resulting from changes in coverage may be due immediately as a separate transaction. If the policy is issued with a final fully discounted premium less than $500, the policy must be billed on an annual basis.

VIII. RENEWALS

The policy will be renewed upon receipt of the required premium on or before the date of each successive policy period. The renewal premium shall be based on rates in effect on the renewal or anniversary date. The applicable forms and endorsements must be made a part of the policy. Additional premiums for policy changes occurring during the current policy term shall be computed pro rata of the annual premium.

IX. SPECIAL PROVISIONS

A. Retroactive Coverage

This extension covers incidents which occurred subsequent to the prior carrier's retroactive date, but which are neither known nor reported as of the inception date of the replacement coverage written by Professional Solutions Insurance Company. The insured may apply for the Retroactive Date (shown on the Coverage Summary) that is equal to the retroactive date shown on the previous policy.

Premium for this extension is derived by rating the policy based upon the claims made step factor determined by using the previous carrier's retroactive date.

B. Basic Reporting Extension

This provision applies when coverage under the policy ends, either by action of the insured or the Company through cancellation, termination or non-renewal.

Under the circumstances stated above, the Company will provide a thirty (30) day Basic Reporting Extension which allows claims to be reported during this time that result from incidents that happened during the time the coverage was in force. The thirty (30) day Basic Reporting Extension does not apply if the insured purchases any subsequent insurance that replaces in whole or in part the coverage provided by this policy.

Within thirty (30) days of when the policy coverage terminates, the Company must advise the insured of the availability of Extended Reporting Coverage, the premium cost, and the importance of buying this additional coverage extension, commonly called "Tail Coverage".

The insured will have the greater of sixty (60) days from the date the coverage is terminated, or thirty (30) days from the date of notice, to accept the Extended Reporting Coverage in writing.

C. Extended Reporting Coverage, also called Tail Coverage

Extended Reporting Coverage will be provided for an unlimited time period with aggregate liability limits equal to or less than those of the expired coverage to report claims which arose from incidents that occurred when the coverage was in force. The liability limits provided by this option are the only limits that shall be applicable to the unlimited time period designated above. Extended Reporting Coverage can be applied to individual or entity policies.

The following factors will be applied to the undiscounted mature claims made premium in effect at the time the policy is terminated to calculate the extended reporting endorsement premium:

# of Years Completed in Claims Made Program	Tail Factor
1	0.92
2	1.43
3	1.70
4+	1.87

Professional Solutions Insurance Company cannot cancel the Extended Reporting Coverage except for non-payment of the additional premium. Premium is due in full at the time of purchase; no payment plans will be offered.

The Company provides Extended Reporting Coverage automatically, at no additional charge, under the following circumstances:

1. The insured dies; or
2. The insured becomes permanently disables and is unable to continue their duties as a licensed insured; or
3. The insured retires. The insured must be age fifty-five (55) or older and have five (5) years of continuous coverage with Professional Solutions Insurance Company in order to qualify for free Extended Reporting Coverage.

D. Change in Rating Classification

In the event of a change in exposure or medical specialty of the practitioner, a charge reflecting the difference between the previous and such new exposure or specialty shall be calculated and collected at the time of such change unless:

1. otherwise eligible for Extended Reporting Coverage at no charge;

2. with regard to medical specialty, both the prior and the current specialty fall within the same class;
3. the exposure or medical specialty of the practitioner changed more than 4 years prior while insured under claims made coverage; or
4. the exposure or medical specialty of the practitioner changed while insured under occurrence coverage.

E. New Practitioner

A new practitioner is defined as a person who has completed his or her training within the previous six months, whose only contact with patients has been in the course of his or her training, and who has not been previously insured by Professional Solutions Insurance Company.

1st year	50% credit
2nd year	30% credit
3rd year	10% credit

Those who receive a new practitioner credit will not be eligible to receive any further credits, except for Size of Risk.

F. Part-Time Practitioner

A practitioner must practice 20 hours or less per week to become eligible for this credit. The insured must complete an application for part-time credit. If the application is approved, credits will be given by year according to the following schedule:

1st year	20% credit
2nd year	30% credit
3rd year	40% credit
4th year	50% credit

Those who receive a part-time practitioner credit will not be eligible to receive any further credits, except for Size of Risk.

G. Locum Tenens

Locum Tenens working in the place of an insured shall be provided coverage at no additional premium, for a period not to exceed forty-five (45) days per policy term. A completed application must be submitted to the company for prior underwriting approval.

H. Moonlighting Resident

Following graduation from medical school, a physician may elect to enter a residency program. Third and fourth year medical residents will be charged at the reduced rate of 50% applied to the undiscounted base rate. Those who qualify for this rating will not be eligible for any additional scheduled or experience rating.

SCHEDULED RATING

Professional Solutions Insurance Company will use the following schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of Professional Solutions Insurance Company uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the company.

The premium for a risk may be modified in accordance with the following, subject to a maximum modification of a 15% credit to a 40% debit to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this scheduled rating plan are subject to periodic review. The actual determination of the appropriate credit or debit will be determined through the underwriting review of the applicant's application.

1. **Cumulative Years of Patient Experience: 5% Credit**

   Insureds who have demonstrated a stable, longstanding practice and/or significant degree of experience in their area of medicine.

2. **Classification Differences: 5% Credit / 15%-25% Debit**

   Characteristics of a particular insured that differentiate the insured from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.

3. **Implementation of Loss Control Procedures: 3% or 5% Credit**

   In order to qualify for this credit, the insured must demonstrate that credible loss control procedures have been properly implemented, and that these procedures will reduce the frequency and severity of claims.

4. **Number / Type of Patient Exposure: 5%-10% Debit**

   Size and/or demographics of the patient population, which influences the frequency, and/or severity of claims.

5. **Board Certification Credit: 3% or 5% Credit**

   In order to receive this credit, the insured must provide documentation of current board certification in one or more specialties of the insured's current practice.

XI. ADDITIONAL CREDITS

Size of Risk Credit

Insureds who are part of or employees of a professional association, corporation, or other group who become insureds of Professional Solutions Insurance Company shall be eligible for a credit based on the volume of premium brought to Professional Solutions Insurance Company. Insureds may receive this credit in addition to the other individual credits available. The size of risk credit will be applied to the undiscounted, total aggregate premium of the individual insureds, plus the corporation charge.

Premium	Credit
$100,001 - $200,000	.50%
$200,001 - $300,000	1.0%
$300,001 - $400,000	1.5%
$400,001 - $500,000	2.0%
$500,001 - $600,000	2.5%
$600,001 - $700,000	3.0%
$700,001 - $800,000	3.5%
$800,001 - $900,000	4.0%
$900,001 - $1,000,000	4.5%
over $1,000,000	5.0%

XII. EXPERIENCE RATING

Claims free credits

A claim is defined as a claim closed with incurred indemnity equal to or greater than $10,000.00.

A claim free credit shall apply if the insured has achieved at least 3 years without a claim.

The following schedule will apply:

3 yrs	5%
4 yrs	6%
5 yrs	7%
6 yrs	8%
7 yrs	9%
8 yrs	10%
9yrs	11%
10 yrs	12%
11 yrs	13%
12 yrs	14%
13 yrs +	15%

Claims debits

Claim debit factors – individual policy:

Three (3) claims opened in the past five (5) years:	5%
Four (4) claims opened in the past five (5) years:	7%
Five (5) claims opened in the past five (5) years:	10%

Claim debit factors – partnership/corporate policy:

# OF CLAIMS IN 5 YEARS	FACTOR
1-2	1.000
3-4	1.500

The debit will not be based on an action that was filed or settled more than five (5) years immediately preceding the issuance or renewal of the policy.

Documentation, including copies of judgments, awards or stipulations of settlement will be requested and reviewed where available.

To obtain and verify experience applicable to each prospective insured, the Company will seek claim information from:

a. The applicant
b. The agent or broker
c. All previous insurers with respect to the experience period in question.

Solo Practitioner Corporation with Shared Limits of Liability Endorsement- Form PSIC-CM-18

This endorsement provides a shared limit of liability at no additional charge to an insured's professional entity, as long as the entity does not employ any other licensed health care providers.

Partnership, Corporation or Professional Association With Separate Limits of Liability Endorsement-Form PSIC-CM-03

This endorsement provides a separate limit of liability to a partnership, corporation or professional association. Coverage is provided only to the extent of the entity's liability for the providing of professional services within the scope and course of employment by a person included within the definition of "Persons Insured" under the policy.

Multiple Partnership, Corporation or Professional Association Endorsement- Form PSIC-CM-19

This endorsement provides a separate limit of liability that will be shared between multiple partnership(s) or corporation(s) or professional association(s). Coverage is provided only to the extent of the entities' liability for the providing of professional services within the scope and course of employment by a person included within the definition of "Persons Insured" under the policy.

Ancillary Medical Personnel Coverage Endorsement- Form PSIC-CM-20

This endorsement provides coverage for licensed ancillary medical personnel to share the separate limit of liability for the entity stated on the declaration page. Coverage is provided only for the additional liability imputed as a licensed health care provider and only while acting within the scope of licensure and as an employee of the insured entity stated on the endorsement.

Professional Organization as Additional Insured Endorsement- Form PSIC-CM-21

This endorsement will be utilized for adding a shared limit for a legal entity/corporation owned by the individual insured and/or insured members of the entity (e.g. for those that do not qualify for the sole practitioner's shared limit coverage and that do not purchase corporation separate limits). The charge for this endorsement will be 5% of the named insured's base premium. This form may be added to more than one individual insured's policy.

Ancillary Medical Personnel Shared Coverage Endorsement- Form PSIC-CM-22

This endorsement will be utilized for adding coverage for an employed, licensed mid-level ancillary provider of an insured that does not desire a separate limit, but that would otherwise be eligible for coverage with PSIC (to be used for other than the sole practitioner and for insureds that do not purchase separate entity limit coverage) to provide coverage for claims made against the insured individual or corporation named on the declaration page due to the action of the employee under the insured's direction and supervision, that would lead to a claim. The charge for this endorsement will be 5% of the highest rated insured's base premium for each licensed ancillary provider, except for Nurse Anesthetists, which will be 15%.

Additional Insured Endorsement-Form PSIC-CM-05

This endorsement provides coverage for an additional insured. This is an optional endorsement. The charge for this endorsement will be 15% of the base corporation/partnership premium.

Temporary Leave of Absence Endorsement-Form PSIC-CM-06

This endorsement may be utilized if an insured must take a leave of absence from their practice. Insureds who become disabled or take a leave of absence shall become eligible for suspension of coverage at a rate reduction of 90% of the otherwise applicable rate for the period of disability or leave of absence. The period

must extend for a minimum length of sixty (60) days or more up to a maximum of one hundred eighty (180) days or until renewal. The lower premium will apply retroactively to the first day of the disability or leave.

This option provides continued protection to the provider who experiences a temporary interruption in his or her practice (subject to the stated eligibility requirements), for claims arising from acts, errors or omissions which occurred prior to the inception of the disability or leave. There is no coverage for acts, errors or omissions during the leave or disability period. Because the policy does not cancel, there is no need for the purchase of Extended Reporting Coverage (Tail).

If disabled, proof of disability must be submitted to the Company for approval, and the calculation of the credit will be on a pro rata basis for the period of the qualifying disability.

While on disability or leave, credit toward extended reporting vesting will continue to accrue, and the insured must continue to pay premiums when due.

Eligible Situations For Temporary Leave of Absence: Short-Term Disability, Maternity Leave, Military Leave or any other reason pre-approved by Professional Solutions Insurance Company – Does not apply to vacations

Extended Reporting Endorsement-Form PSIC-CM-07

This endorsement provides coverage for an unlimited time period with aggregate liability limits equal to or less than those of the expired coverage to report claims, which arose from incidents that occurred when the coverage was in force. The liability limits provided by this option are the only limits that shall be applicable to the unlimited time period designated above. This endorsement can be applied to group or entity policies.

Medical Laboratory Endorsement-Form PSIC-CM-10

This endorsement provides a shared limit of liability to a medical laboratory facility. The premium for the endorsement is based on the following:

a. at no additional charge if such laboratory is not a separate entity. Coverage is limited to the testing of the insured's own patients.

b. as an additional insured at 25% of the mature Class 1 rate, if such laboratory is a separate entity. Coverage is limited to the testing of the insured's own patients.

Specialty Classification Amendment Endorsement-Form PSIC-CM-11

This endorsement will be attached to the policy if the insured amends their medical specialty during the policy period. This endorsement will extend coverage for claims that are reported under the insured's previous medical specialty. The premium will be adjusted based on the change of the specialty classification.

XIV. Classification Plan – Refer to rate sheet for base rate information.

ISO Specialty Codes M.D.	ISO Specialty Codes D.O.	Class	Description	FACTOR
80230		1	Aerospace Medicine	0.650
80254		1	Allergy/Immunology	0.650
80256		1	Dermatology - No Surgery	0.650
80240		1	Forensic Medicine	0.650
80248		1	Nutrition	0.650
80233		1	Occupational Medicine	0.650
80263		1	Ophthalmology - No Surgery	0.650
80235		1	Physiatry/Physical Medicine	0.650
80231		1	Preventive Medicine - No Surgery	0.650
80251		1	Psychosomatic Medicine	0.650

80236	1	Public Health	0.650
80237	2	Diabetes No Surgery	0.850
80238	2	Endocrinology - No Surgery	0.850
80243	2	Geriatrics - No Surgery	0.850
80244	2	Gynecology - No Surgery	0.850
80260	2	Nephrology - No Surgery	0.850
80262	2	Nuclear Medicine	0.850
80268	2	Physicians - No Surgery N.O.C.	0.850
80995	2	Podiatry - Soft Tissue	0.850
80249	2	Psychiatry including child	0.850
80252	2	Rheumatology - No Surgery	0.850
80255	3	Cardiovascular Disease - No Surgery	1.000
80420	**3**	**Family Phys. Or Gen. Prac. - No Surgery**	**1.000**
80241	3	Gastroenterology - No Surgery	1.000
80245	3	Hematology - No Surgery	1.000
80246	3	Infectious Diseases - No Surgery	1.000
80258	3	Laryngology - No Surgery	1.000
80259	3	Neoplastic Diseases - No Surgery	1.000
80302	3	Oncology No Surgery	1.000
80264	3	Otology - No Surgery	1.000
80265	3	Otorhinolaryngology - No Surgery	1.000
80266	3	Pathology No Surgery	1.000
80269	3	Pulmonary Diseases - No Surgery	1.000
80247	3	Rhinology - No Surgery	1.000
80257	4	Internal Medicine - No Surgery	1.250
80287	4	Nephrology - Minor Surgery	1.250
80301	4	Oncology - Minor Surgery	1.250
80289	4	Ophthalmology - Minor Surgery	1.250
80114	4	Opthalmology - Surgery	1.250
80267	4	Pediatrics - No Surgery	1.250
80298	4	Pulmonary Diseases - Minor Surgery	1.250
80281	5	Cardiovascular Disease - Minor Surgery	1.500
80282	5	Dermatology - Minor Surgery	1.500
80271	5	Diabetes - Minor Surgery	1.500
80272	5	Endocrinology - Minor Surgery	1.500
80274	5	Gastroenterology - Minor Surgery	1.500
80276	5	Geriatrics - Minor Surgery	1.500
80277	5	Gynecology - Minor Surgery	1.500
80278	5	Hematology - Minor Surgery	1.500
80279	5	Infectious Diseases - Minor Surgery	1.500
80284	5	Internal Medicine - Minor Surgery	1.500
80285	5	Laryngology - Minor Surgery	1.500
80261	5	Neurology - No Surgery	1.500
80290	5	Otology - Minor Surgery	1.500
80291	5	Otorhinolaryngology - Minor Surgery	1.500
80294	5	Physicians - Minor Surgery N.O.C.	1.500
80253	5	Radiology Diagnostic - No Surgery	1.500
80270	5	Rhinology - Minor Surgery	1.500
80145	5	Urological Surgery	1.500
80151	6	Anesthesiology	1.650
80421	6	Family Phys. Or Gen. Prac.- Minor Surgery	1.650
80283	6	Intensive Care Medicine	1.650
80286	6	Neoplastic Diseases - Minor Surgery	1.650

80288	6	Neurology - Minor Surgery	1.650
80292	6	Pathology - Minor Surgery	1.650
80293	6	Pediatrics - Minor Surgery	1.650
80101	7	Broncho-Esophagology	2.150
80103	7	Endocrinology Surgery	2.150
80104	7	Gastroenterology Surgery	2.150
80105	7	Geriatrics Surgery	2.150
80804	7	Neonatal/Perinatal Medicine	2.150
80108	7	Nephrology Surgery	2.150
80159	7	Otorhinolaryngology - No Plastic Surgery	2.150
80280	7	Radiology Diagnostic - Minor Surgery	2.150
80115	8	Colon and Rectal Surgery	2.500
80106	8	Laryngology Surgery	2.500
80107	8	Neoplastic Surgery	2.500
80164	8	Oncology Surgery	2.500
80158	8	Otology	2.500
80136	8	Radiology Including Radiation Therapy	2.500
80160	8	Rhinology Surgery	2.500
80102	9	Emergency Medicine - No Major Surgery	3.000
80117	9	General Prac. or Family Prac. Surgery	3.000
80143	9	General Surgery	3.000
80169	10	Hand Surgery	3.350
89154	10	Orthopedic Surgery - No Spine	3.350
80155	10	Otorhinolaryngology w/Plastic Surgery	3.350
80166	11	Abdominal Surgery	3.750
80157	11	Emergency Medicine Surgery	3.750
80167	11	Gynecology Surgery	3.750
80170	11	Head and Neck Surgery	3.750
80141	12	Cardiac Surgery	4.500
80150	12	Cardiovascular Disease Surgery	4.500
80154	12	Orthopedic Surgery - Including Spine	4.500
80156	12	Plastic N.O.C. Surgery	4.500
80144	12	Thoracic Surgery	4.500
80171	12	Traumatic Surgery	4.500
80146	12	Vascular Surgery	4.500
80153	13	Obstetrics Gynecology Surgery	5.500
80168	13	Obstetrics Surgery	5.500
80152	14	Neurology Surgery	6.750

Ancillary Provider Rating:

Ancillary Provider	Separate Limits Factor
Physician Assistant	0.200
Surgical Assistant	0.200
Nurse Practitioner	0.200
Psychologist	0.250
Nurse Anesthetist	0.560

XV. Partnership-Corporation-Professional Association Coverage

A. Sole Practitioner Corporation:

Coverage for an insured's professional entity may be written with a shared limit of liability at no additional charge as long as the entity does not employ any other licensed health care providers.

B. Separate Limits of Liability:

Coverage for partnerships, corporations, or professional associations may be written with a separate limit of liability. The premium charge for separate limits will be a percentage of the total undiscounted liability premium for all practitioners. The percentage will vary based on the number of insureds in the corporation.

Number of Insureds	Percent
2-5	15.0%
6-9	12.0%
10-19	9.0%
20-49	7.0%
50 or more	5.0%

C. Multiple Corporations:

Coverage for multiple partnership(s), corporation(s) or professional association(s) may be written with a separate limit of liability shared among the multiple entities. The premium charge for separate limits will be a percentage of the total undiscounted liability premium for all practitioners in the primary entity. The percentage will vary based on the number of insureds in the primary entity. There is no additional charge for each additional entity that will share in this separate limit.

Number of Insureds	Percent
2-5	15.0%
6-9	12.0%
10-19	9.0%
20-49	7.0%
50 or more	5.0%

D. Ancillary Medical Personnel Coverage:

Coverage for licensed ancillary medical personnel may be written so the ancillary medical personnel share the separate limit of liability with the entity stated on the declaration page. The premium charge for sharing the entity's separate limits will be a factor of the highest classed insured at a mature claims made step for each ancillary provider that will be named on the endorsement.

Licensed Ancillary Provider	Shared Limits Factor
Physician Assistant	0.050
Surgical Assistant	0.050
Nurse Practitioner	0.050
Psychologist	0.050
Nurse Anesthetist	0.150

XVI. Rates

Physicians and Surgeons Mature Claims Made Rate (for Class 3 provider @ 100/300 limits)

Illinois Territory 01 - **(Cook, Madison and St. Clair counties)**	**$12,110.00**
Illinois Territory 02 - **(DePage, Kane, Lake, McHenry and Will counties)**	**$8,967.00**
Illinois Territory 03 - **(Champaign, Macon, Jackson, Vermillion, Sangamon, DeKalb, Kankakee, LaSalle, Ogle, Randolph, Winnebego and Jackson counties)**	**$7,911.00**
Illinois Territory 04 - **(Remainder of State)**	**$5,800.00**

Increase limit factors: The applicable limit factor is determined by the chosen limit option on the application.

Limits of Liability	Increase Limit Factors
$100,000/$300,000	1.000
$200,000/$600,000	1.375
$250,000/$750,000	1.500
$500,000/$1,000,000	1.875
$1,000,000/$3,000,000	2.500
$2,000,000/$4,000,000	3.125

Claims-Made Step Factors:

Year	Claims-Made Step Factor
1	0.35
2	0.66
3	0.90
4	0.98
Mature	1.00

6th Month Rule: If the period between the retroactive date and the policy effective date is less than 6 months, rate at year 1. If the period is more than 6 months, rate at year 2, with each of the next consecutive claims made step increases applied at each renewal.